

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PAYMENTS FOR  
POWER WHEELCHAIRS**



**Inspector General**

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# ***Office of Inspector General***

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## ‡ A B S T R A C T

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In 2001, Medicare and its beneficiaries paid \$513 million for all K0011 power wheelchairs. Payments for this procedure code have risen dramatically, increasing 43 percent from the year 2000 to 2001 alone. In order to determine whether K0011 power wheelchairs provided in 2001 met Medicare's coverage and documentation requirements, we selected a simple random sample of 300 claims. We then contacted the suppliers, ordering physicians, and beneficiaries associated with these claims, and provided medical documentation to an independent contractor for a coverage review. Our review indicated most claims did not meet Medicare's coverage criteria for K0011 power wheelchairs; however, some claims met criteria for a less expensive mobility device. We also identified a number of other problems with Medicare claims for K0011 power wheelchairs, including missing and incomplete supporting documentation, and equipment that is not used by Medicare beneficiaries. We recommend that the Centers for Medicare & Medicaid Services (CMS) improve compliance with Medicare's coverage criteria for power wheelchairs. We suggest that CMS require durable medical equipment regional carriers to revise current coverage policies for power wheelchairs; conduct frequent reviews of K0011 claims; and educate ordering physicians and beneficiaries about power wheelchair coverage criteria.

# ‡ E X E C U T I V E S U M M A R Y

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## OBJECTIVE

To determine whether power wheelchair claims meet Medicare's coverage and documentation requirements, and to examine beneficiaries' use of equipment and selection of suppliers.

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## BACKGROUND

Title XVIII of the Social Security Act established coverage and benefits under Part B of the Medicare program. Medicare beneficiaries covered by Part B are eligible to receive durable medical equipment (DME), such as power wheelchairs, when the items are deemed medically necessary by a physician and needed for use in the home. To qualify for power wheelchairs, patients must be bed or chair confined, unable to operate a wheelchair manually, and capable of safely operating the controls of the power wheelchair.

According to supplier manuals published by the durable medical equipment regional carriers (DMERCs), initial claims for power wheelchairs must include a Certificate of Medical Necessity (CMN) that has been signed and dated by a physician. The supplier must maintain a copy of this signed CMN in their records. Suppliers must also maintain documentation showing that items were delivered to beneficiaries.

In calendar year (CY) 2001, Medicare and its beneficiaries paid a total of \$513 million for procedure code K0011, a standard-weight power wheelchair with programmable control parameters. Medicare allows approximately \$5,000 for each K0011 power wheelchair claim. Total allowances for the K0011 code have risen dramatically, increasing 43 percent from the year 2000 to 2001 alone. Although many beneficiaries need power wheelchairs, DMERCs and the Office of Inspector General (OIG) have identified fraud cases involving power wheelchairs that were not supplied, not medically necessary, or both.

For this inspection, we selected a simple random sample of 300 claims for procedure code K0011 from the Centers for Medicare & Medicaid Service's (CMS's) 2001 National Claims History File. We then collected CMNs and delivery documentation from suppliers, and medical records from ordering physicians. Using Medicare coverage criteria, an independent medical review contractor conducted a coverage review of medical records received from physicians or suppliers. We did not assess the appropriateness of the Medicare coverage criteria themselves. We

also spoke with 166 of the 300 beneficiaries on whose behalf Medicare paid sample claims.

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## FINDINGS

**Most reviewed claims did not meet Medicare’s coverage criteria for a K0011 power wheelchair; however, some claims may have met coverage criteria for a less expensive mobility device.** Almost one-third of reviewed claims did not meet Medicare’s coverage criteria for any type of wheelchair. An additional 45 percent of reviewed claims did not meet Medicare’s coverage criteria for the K0011 power wheelchair but may have met criteria for another type of wheelchair or scooter (also known as a power-operated vehicle). Physicians, however, may not be familiar with Medicare’s coverage criteria when ordering mobility devices for their patients. The only document that physicians are required to review and complete when ordering a wheelchair is the CMN. Coverage guidelines are not listed on the CMN for power wheelchairs, and medical necessity questions on CMNs are not totally consistent with coverage policy. In CY 2001, Medicare and its beneficiaries paid an estimated \$178 million for claims that did not meet Medicare’s coverage criteria for K0011 power wheelchairs. Only 13 percent of reviewed claims actually met the coverage criteria for K0011 power wheelchairs. Due to insufficient documentation, the reviewer could not determine whether another 11 percent of reviewed claims met the coverage criteria for the K0011 power wheelchair.

**For over half of claims, CMNs and/or delivery documentation were missing, incomplete, or dated after the date of service.** For 5 percent of K0011 power wheelchair claims, suppliers did not provide a CMN and/or proof of delivery. We estimate that Medicare and its beneficiaries paid an additional \$19 million in CY 2001 for K0011 claims that could not be substantiated by either a CMN or delivery documentation. Even when suppliers did submit CMNs or proof of delivery, the documentation was often incomplete or dated after the date of service.

**Most responding beneficiaries reported using their power wheelchairs at home; other beneficiaries either do not use their power wheelchairs or use them for outside activities only.** Sixty-eight percent of beneficiaries who responded to our survey (113 of 166) currently use their power wheelchairs inside their homes. Four percent of respondents said that they have never used their power wheelchairs.

An additional 12 percent of respondents said that they do not currently use their power wheelchairs but have used them in the past. Another 12 percent of respondents reported that they currently use their power wheelchairs outside the home only.

**Many beneficiaries who completed our survey responded to suppliers' direct marketing practices.** Almost one-quarter of beneficiaries who responded to our survey learned about their power wheelchair suppliers from a television commercial. An additional 9 percent of respondents chose their suppliers after receiving something in the mail. Another 4 percent of respondents obtained their power wheelchairs from suppliers who visited their homes.

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## RECOMMENDATION

A power wheelchair can greatly improve the quality of life for an individual who otherwise suffers from limited mobility. However, our coverage review indicates that Medicare and its beneficiaries spent an estimated \$178 million in 2001 for K0011 power wheelchairs that did not meet Medicare's coverage criteria. These inappropriate payments waste taxpayer dollars that could otherwise fund appropriate equipment for needy Medicare beneficiaries.

CMS has recognized the dramatic growth in payment for and utilization of power wheelchairs and is currently taking steps to address these issues as part of its 10-point plan of action to curb power wheelchair fraud, waste, and abuse. In fact, CMS has already begun implementing some of the options listed in the following recommendation. We believe that continued attention to Medicare payments for K0011 power wheelchairs is warranted.

**We recommend that CMS improve compliance with Medicare's coverage criteria for K0011 power wheelchairs.** CMS should consider the following options in order to improve compliance:

*Require DMERCs to revise the coverage policy for K0011 power wheelchairs to include specific information about the medical conditions for which Medicare will cover this item.* Our findings show that many beneficiaries did not meet coverage criteria for the K0011 power wheelchair but may have qualified for a lower-priced power wheelchair, a scooter, or a manual wheelchair. Given that patients frequently received K0011 power wheelchairs when their conditions warranted a lower level of equipment, CMS should evaluate the medical conditions and functional abilities that are associated with different types of mobility aids and

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describe these conditions/abilities in the coverage policies. This will ensure that beneficiaries have access to the equipment that is most appropriate for their conditions. DMERCs should also consider removing guidelines regarding the specialties of physicians who order scooters. In addition, DMERCs should require that physicians treat the patients for whom they order equipment.

Require DMERCs to conduct frequent reviews of the K0011 procedure code to ensure appropriate payments. When performing reviews of K0011 claims, DMERCs should ensure that suppliers have complete and thorough documentation. DMERCs should also request medical records from ordering physicians in addition to supporting documentation from suppliers. DMERCs should also consider routinely contacting beneficiaries during the course of reviews to ensure that the equipment provided by suppliers is appropriate for and useful to beneficiaries.

Educate ordering providers about Medicare's coverage criteria for different types of assistive devices, including power wheelchairs, manual wheelchairs, and scooters. Ordering providers play a key role in determining the need for and utilization of equipment billed to Medicare. According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, payment may not be made for power wheelchairs unless a physician, physician's assistant, nurse practitioner, or clinical nurse specialist has conducted a face-to-face examination of the patient and written a prescription for the item. CMS relies on the clinical judgment of these health care professionals to ensure that Medicare only pays for items that are most appropriate for beneficiaries. However, ordering providers may not be aware of Medicare's coverage requirements for mobility devices. A lack of provider education about Medicare's coverage criteria for wheelchairs could adversely affect physicians' ability to make informed decisions about the types of mobility devices that are best for their patients, which could ultimately lead to inappropriate Medicare payments.

Educate Medicare beneficiaries about coverage criteria for wheelchairs and scooters. Beneficiaries also play a key role in ensuring that Medicare does not pay for medically unnecessary or unused items. Beneficiaries who are knowledgeable about Medicare's coverage guidelines can make more informed choices about the assistive devices that would meet both their own needs and Medicare's coverage requirements.

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## AGENCY COMMENTS

CMS concurred with our recommendation and agreed with our suggestions regarding coverage policy revisions and provider and beneficiary education. They also agreed that more frequent reviews of the K0011 code will help ensure appropriate payments; however, they do not believe that routinely contacting beneficiaries would yield meaningful results. CMS confirmed that they have already begun implementing many of our report recommendations through their power wheelchairs workgroup, which was established to develop a plan of action to ensure that payments are only made for power wheelchairs that are reasonable and necessary. Specific actions by CMS include: requiring DMERCs to develop a complete picture of a patient's medical condition before making medical review coverage determinations; developing a regulation to remove the current requirement that scooters be prescribed only by certain specialists; and developing a regulation that requires a face-to-face examination by the treating physician prior to ordering a power wheelchair. CMS is also poised to release an educational campaign designed to provide both physicians and beneficiaries with needed information regarding Medicare and DMERC coverage policy. The full text of CMS's comments is presented in Appendix B.



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## OBJECTIVE

To determine whether power wheelchair claims meet Medicare's coverage and documentation requirements, and to examine beneficiaries' use of equipment and selection of suppliers.

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## BACKGROUND

Title XVIII of the Social Security Act established coverage and benefits under Part B of the Medicare program. Medicare beneficiaries covered by Part B are eligible to receive durable medical equipment (DME) deemed medically necessary by a physician. Medicare Part B classifies certain items of DME, such as wheelchairs, as capped rental items. Payments for capped rental items are made on a monthly basis not to exceed 15 continuous months; however, power wheelchairs may be purchased outright. A DME supplier must give beneficiaries that qualify for a power wheelchair the option to purchase the item when it is first provided. If the beneficiary chooses to purchase the power wheelchair at that time, the supplier receives a lump-sum payment. Medicare beneficiaries are responsible for 20 percent of this lump-sum payment in the form of coinsurance.

To obtain reimbursement for medical equipment such as power wheelchairs, suppliers submit claims to one of four durable medical equipment regional carriers (DMERCs). The Centers for Medicare & Medicaid Services (CMS) contracts with these DMERCs to process and pay medical equipment claims.

### **Medicare Coverage Criteria for Wheelchairs and Scooters**

Medicare covers many different types of wheelchairs, from basic manual wheelchairs and scooters (also known as power-operated vehicles) to high-end power wheelchairs. Section 1862(1)(A) of the Social Security Act states that all DME items provided under Medicare Part B, including wheelchairs and scooters, must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." In addition, Section 1861(n) of the Social Security Act stipulates that patients must need the equipment for use in their homes. Payment is approved for the least costly medically acceptable item. Options that are beneficial primarily in allowing beneficiaries to perform leisure or recreational activities are not covered by Medicare.

Coverage Criteria for Manual Wheelchairs. A manual wheelchair is covered if the patient's condition is such that without the use of a wheelchair, the patient would otherwise be bed or chair confined. Additional criteria may apply for non-standard manual wheelchairs such as lightweight, ultra-lightweight, and heavy-duty manual wheelchairs.

Coverage Criteria for Scooters. Unlike other mobility devices covered by Medicare, a scooter must be prescribed by a specialist. A scooter is usually covered only if it is ordered by a physician in one of the following specialties: Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology. For coverage of scooters, all of the following additional criteria must be met:

- The patient's condition is such that, without the use of a wheelchair, the patient would not be able to move around in their residence.
- The patient is unable to operate a manual wheelchair.
- The patient is capable of safely operating the controls for the scooter.
- The patient can transfer safely in and out of the scooter and has adequate trunk stability to be able to safely ride in the scooter.

Coverage Criteria for Power Wheelchairs. A power wheelchair is covered when all of the following criteria are met:

- The patient's condition is such that, without the use of a wheelchair, the patient would otherwise be bed or chair confined.
- The patient's condition is such that a wheelchair is medically necessary, and the beneficiary is unable to operate a wheelchair manually.
- The patient is capable of safely operating the controls for the power wheelchair.

According to the DMERC supplier manuals, "A patient who requires a power wheelchair usually is totally non-ambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease/condition." Unlike scooters, a physician does not need to have a particular specialty in order to prescribe a power wheelchair.

**Documentation Required by DMERCs for Power Wheelchair Claims**

According to the DMERC supplier manuals, initial claims for power wheelchairs must include a Certificate of Medical Necessity (CMN).

These initial CMNs are usually submitted to DMERCs electronically. The CMN for power wheelchairs, CMS Form 843, is divided into different sections. Suppliers complete sections relating to their company, the beneficiary, and the ordering physician. They also provide information about the type of equipment ordered, their charge for the equipment, and the Medicare allowance. The ordering physician or an employee of the physician completes sections regarding the patient's medical condition. In order for a power wheelchair to be covered by Medicare, the physician must respond, "Yes" to the following questions on the CMN:

- Does the patient require and use a wheelchair to move around in their residence?
- Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
- Is the patient unable to operate any type of manual wheelchair?

The ordering physician must then sign and date the CMN. The supplier must maintain a hard copy of this signed CMN in its records and present it to the DMERC upon request. Information submitted to the DMERC by the supplier must be substantiated by documentation in the patient's medical records.

According to the Medicare Program Integrity Manual and the supplier manuals, suppliers must also maintain documentation showing that items were delivered to beneficiaries. Delivery documents must include the date of delivery, the patient's name and signature, the quantity of the item(s) delivered, a detailed description of the item(s) delivered, and the brand name and serial number of the item(s). Proof of delivery must be available to the DMERC upon request. If a supplier cannot furnish this documentation, the DMERC can deny the claim and request an overpayment.

#### **Concerns About Medicare Payments for Power Wheelchairs**

In calendar year (CY) 2001, Medicare and its beneficiaries paid \$538 million for all power wheelchairs. Payments for procedure code K0011, a standard-weight power wheelchair with programmable control parameters, accounted for 95 percent of this total (\$513 million). In CY 2001, Medicare allowed approximately \$5,000 for each K0011 power wheelchair. Payments for the K0011 code have been rising dramatically, increasing 43 percent from the year 2000 to 2001 alone.

In September 2003, CMS and the Office of Inspector General (OIG) issued a joint press release that cited a number of fraud cases involving power wheelchairs that were not supplied, not medically necessary, or both. OIG has also investigated cases where suppliers billed Medicare for a K0011 power wheelchair but provided beneficiaries with scooters, which are reimbursed at less than half the amount of K0011 power wheelchairs. In order to address significant increases in allowances for power wheelchairs and indications of improper billing activity, CMS has launched a campaign to curb abuse of the Medicare program by unscrupulous suppliers of mobility products. Initiatives in this campaign include: revising coverage policy for power wheelchairs and scooters to ensure that national policy accurately defines the conditions under which Medicare will cover mobility products; adopting a consistent approach to medical review; clarifying physicians' responsibilities as prescribers of mobility devices; and educating beneficiaries about Medicare coverage guidelines.

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## METHODOLOGY

### Sample Design

We focused our review on procedure code K0011, which is a standard-weight power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking.

We extracted all paid claims for procedure code K0011 from CMS's 2001 National Claims History File. According to this claims data, 99 percent of all expenditures for K0011s were for first-month purchases.

Therefore, our sampling frame of 100,124 claims included only K0011 power wheelchairs that were purchased by the beneficiary in the first month. Claims for rentals were not included. We selected a simple random sample of 386 claims from the sampling frame. Using information from CMS's beneficiary enrollment database, we then removed claims associated with deceased beneficiaries. We also removed claims with suppliers or ordering physicians that were under investigation by OIG's Office of Investigations. We removed a total of 86 claims, resulting in a final sample of 300 power wheelchair claims. These 300 sample claims represent an estimated \$394 million in allowances for K0011 power wheelchairs.

### Data Collection

Supplier Contacts. We identified suppliers who submitted the sample claims and contacted these suppliers using address information from

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CMS's National Supplier Clearinghouse. We requested that suppliers provide us with CMNs and additional documentation in support of sample claims. We also requested that suppliers provide delivery records for these sample items.

We made up to three attempts to contact each supplier by overnight mail with a signature request. We received responses for 272 of the 300 claims in our sample. We could not locate suppliers for 17 claims due to incorrect address information; therefore, we did not include these claims in our analysis of supplier documentation. We did not receive responses for 11 claims. For the purposes of our study, we concluded that the suppliers for these claims did not have supporting documentation, and included the claims in our analysis of missing CMNs and delivery documentation. Therefore, a total of 283 claims were used in our analysis of CMNs and delivery documentation.

*Physician Contacts.* Using address information collected from suppliers, we contacted the ordering physicians for sample claims. We requested copies of Medicare beneficiaries' medical records in support of sample claims for power wheelchairs. Specifically, we requested all documentation (including office visit notes, referrals for physical or occupational therapists, and hospital admission histories and discharge summaries) from the 6-month period prior to and including the date on the sample claim.

Suppliers were able to provide physician address information for 271 claims. We made up to three written attempts to contact these physicians. We did not receive responses for 15 claims and were unable to contact ordering physicians for an additional 9 claims due to incorrect addresses. We did receive responses for 247 claims; however, physicians did not submit the requested information for 35 of these claims. For 7 of the 35 claims, the physicians indicated that they never ordered the power wheelchairs. These seven claims have been referred to OIG's Office of Investigations for further development.

*Beneficiary Contacts.* Using numbers obtained from both suppliers and the Internet, we telephoned the beneficiaries for whom sample wheelchairs were ordered. We asked beneficiaries how they learned about suppliers, whether suppliers provided them with equipment, and whether they have used the equipment. We also asked each beneficiary specific questions about the equipment provided, such as the brand name, model number, and serial number of the item.

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We completed telephone interviews with 166 of the 300 beneficiaries in our sample. Responses from these 166 beneficiaries formed the basis for our analysis. We did not project our results to the population. Of the 134 non-respondents, 69 were beneficiaries for whom we could not find telephone numbers, 41 were beneficiaries who could not be reached by telephone, and 24 were beneficiaries who refused to participate.

Coverage Review. We ultimately forwarded a total of 230 medical records received from physicians and/or suppliers to an independent medical review contractor. Claims for these 230 medical records represent an estimated \$303 million in allowances for K0011 power wheelchairs. Table 1 below shows the results of our effort to collect medical information that could be used in a coverage review.

<b>Table 1. Data Collection Results: Records for Coverage Review</b>	
	<b>Number of Claims</b>
<b>Claims That Were Sent for Coverage Review</b>	<b>230</b>
Physician Provided Useable Medical Records	212
Physician Responded But Did Not Provide Useable Medical Records; Supplier Provided Useable Records	11
Physician Could Not Be Contacted But Supplier Provided Useable Medical Records	2
Physician Did Not Respond But Supplier Provided Useable Medical Records	5
<b>Total Claims in Sample</b>	<b>300</b>

Source: OEI Analysis of Supplier and Physician Data Collection Results, 2003

The medical review contractor conducted a coverage review of the records using a data collection instrument jointly developed by our office and the contractor. The coverage review instrument included questions regarding the patient's diagnosis, physical condition, ability to ambulate, and ability to operate a power wheelchair. The reviewer determined whether the K0011 power wheelchair met the Medicare coverage criteria outlined in the DMERC supplier manuals. For cases where the physician reviewer determined that the K0011 power wheelchair did not meet the Medicare coverage criteria, the reviewer indicated whether another, less expensive, mobility device would have been appropriate for the patient, given both the coverage criteria and the information in the medical records. The reviewer had the option of "downcoding" to one of the following mobility devices: a K0010 power wheelchair, which is a standard-weight power wheelchair without programmable controls; a scooter; or a manual wheelchair. It is important to note that we did not specifically request records to support any item other than the K0011 power wheelchair. Also, we did not assess the appropriateness of the Medicare coverage criteria.

#### **Data Analysis**

We reviewed CMNs for sample claims to determine whether the information was complete. We then estimated the proportion of claims for power wheelchairs with incomplete CMNs. We also determined whether suppliers' delivery records for sample wheelchairs included the required information. We analyzed beneficiary survey responses to determine whether suppliers actually provided equipment to the beneficiary and whether beneficiaries used the equipment. We also identified the ways in which beneficiaries learned about their suppliers.

We aggregated data received from the medical review contractor and estimated the proportion of sample claims that did not meet Medicare's coverage criteria for a K0011 power wheelchair. To compute inappropriate payments, we totaled the allowances for all claims that did not meet Medicare's coverage criteria for procedure code K0011. However, we used adjusted allowances for cases where beneficiaries did not meet the coverage criteria for a K0011 power wheelchair but would have qualified for a K0010 power wheelchair, a scooter, or a manual wheelchair. We then computed the difference between the original and adjusted allowances for these claims. Adjusted allowances were derived from the 2001 DME fee schedule ceiling amounts for procedure codes K0010, E1230 (scooter), and K0005 (ultra-lightweight manual wheelchair). We used procedure code K0005 for the adjusted allowance



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because it has the highest reimbursement amount of any manual wheelchair and is, therefore, the most conservative figure.

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

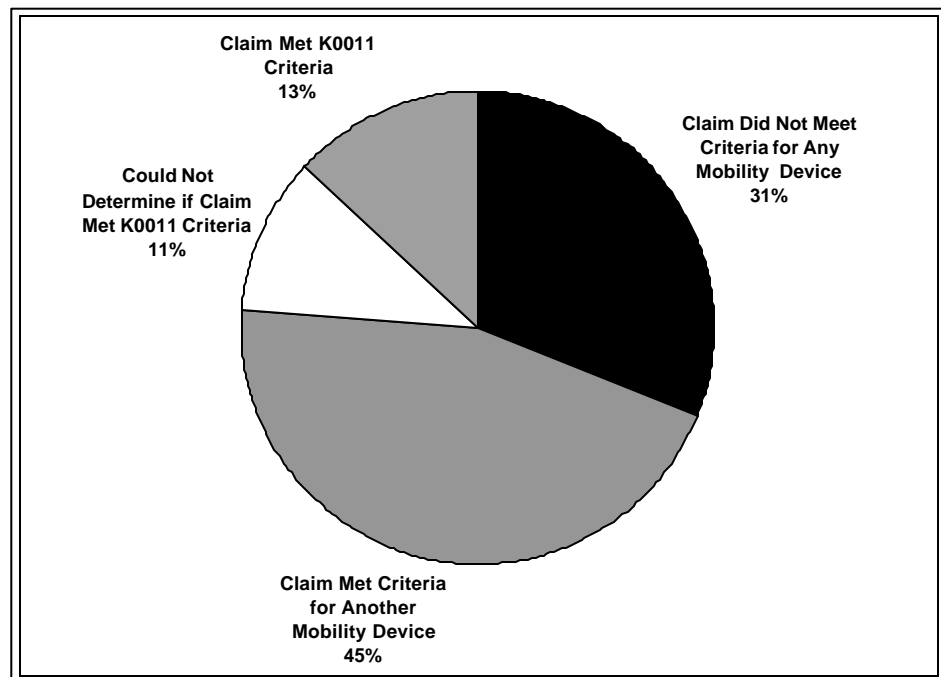
## ‡ FINDINGS

**Most reviewed claims did not meet Medicare's coverage criteria for a K0011 power wheelchair; however, some claims may have met coverage criteria for a less expensive mobility device**

Only a small percentage of reviewed claims (13 percent) met Medicare's coverage criteria for a K0011 power wheelchair, as illustrated in Chart 1 below.

Although 31 percent of claims did not meet coverage criteria for any mobility device, another 45 percent of claims may have met criteria for another, less expensive item.

CHART 1  
Results of Coverage  
Review for K0011  
Power Wheelchairs,  
n = 230.



Source: OEI Analysis of Coverage Review Results, 2003

**Almost one-third of reviewed claims did not meet Medicare's coverage criteria for any type of wheelchair or scooter.**

A medical review contractor determined that 31 percent of reviewed claims did not meet Medicare's coverage criteria for either a K0011 power wheelchair or any other type of wheelchair or scooter. In CY 2001, Medicare and its beneficiaries paid an estimated \$96 million for claims that did not meet Medicare's coverage criteria for any type of wheelchair or scooter. The estimate does not account for any accessories that may have been billed in conjunction with the power wheelchairs (e.g., arm rests, leg rests, and cushions). If a power wheelchair does not meet Medicare's coverage criteria, then any associated accessories would not be covered.

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Beneficiaries in all of these cases were able to ambulate, although some did so with the assistance of a cane or walker. According to the coverage criteria for any type of wheelchair, the patient's condition must be "such that without the use of a wheelchair the patient would otherwise be bed or chair confined." Therefore, if beneficiaries are ambulatory (*i.e.*, not bed or chair confined), they do not qualify for a wheelchair or scooter under Medicare's coverage guidelines. Physicians, however, may not be familiar with this coverage criterion when ordering mobility devices for their patients. Medicare's coverage criteria for power wheelchairs are outlined only in DMERC supplier manuals, which are provided to the suppliers who bill for medical equipment but not the physicians who order it. The only document that physicians are required to review and complete when ordering a wheelchair is the CMN. Coverage guidelines are not listed on the CMN for power wheelchairs, nor do any of the medical necessity questions on the CMN require physicians to address whether patients are non-ambulatory.

**An additional 45 percent of reviewed claims did not meet Medicare's coverage criteria for the K0011 power wheelchair but may have met criteria for another type of wheelchair or scooter.**

According to the medical review contractor, 45 percent of reviewed claims did not meet Medicare's coverage criteria for a K0011 power wheelchair but may have met criteria for a scooter, K0010 power wheelchair, or manual wheelchair. In CY 2001, Medicare and its beneficiaries spent an estimated \$82 million in excessive payments for claims that could have been billed using a code for a less expensive mobility device. Physicians may not be aware of the differences in coverage criteria among the mobility devices available to Medicare beneficiaries. Discrepancies between medical necessity questions on the CMN and coverage criteria could also cause confusion about the medical conditions for which K0011 power wheelchairs would be most beneficial. For example, question 6 in section B of the CMN for power wheelchairs allows physicians to attribute an upper extremity weakness to a cardiopulmonary disease/condition, whereas the coverage guidelines refer only to a neurologic or muscular disease/condition.

Twenty-three percent of reviewed claims did not meet the coverage criteria for a K0011 power wheelchair but would have met the coverage criteria for a scooter. The beneficiaries in these cases were non-ambulatory, unable to self-propel a manual wheelchair, and had sufficient trunk stability and transfer ability to safely operate a scooter. Their medical conditions did not warrant a higher-level power

## F I N D I N G S

wheelchair. Some beneficiaries may have received K0011 power wheelchairs rather than scooters because their ordering physicians were not able to prescribe scooters. A scooter is usually covered only if it is ordered by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology; however, there are no such restrictions for a K0011 power wheelchair, which costs twice as much as a scooter. Guidelines regarding the specialties of physicians who order scooters may actually prevent beneficiaries from getting the equipment that best suits their needs, and could lead to excessive Medicare payments if K0011 power wheelchairs are provided in lieu of scooters.

For 8 percent of reviewed claims, the beneficiary did not meet Medicare's coverage criteria for a K0011 power wheelchair but would have qualified for a K0010 power wheelchair. In most of these cases, the beneficiaries were non-ambulatory with significant trunk instability and upper extremity weakness but did not have a medical condition that would require programmable controls. Medicare coverage requirements do not currently provide any guidance as to the medical conditions that might benefit from programmable controls.

An additional 3 percent of reviewed claims would have met the coverage criteria for a manual wheelchair rather than a K0011 power wheelchair. For these cases, the medical records usually indicated that the beneficiaries were non-ambulatory but had sufficient upper extremity strength to operate some type of manual wheelchair.

Eleven percent of reviewed claims did not meet the coverage guidelines for a K0011 power wheelchair but may have met criteria for another type of wheelchair or scooter. These claims did not meet coverage criteria for a K0011 power wheelchair because the beneficiary did not need programmable controls. However, due to scanty medical documentation, the reviewer was unable to determine what other mobility device may have been appropriate for the beneficiary.

### **Only 13 percent of reviewed claims met the coverage criteria for a K0011 power wheelchair.**

In CY 2001, Medicare paid an estimated \$38 million for claims that met the coverage criteria for K0011 power wheelchairs. The beneficiaries in these cases were clearly non-ambulatory, had upper extremity weaknesses, and required programmable controls, usually due to contractures, tremors, or spasticity.

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**Due to insufficient documentation, the reviewer could not determine whether another 11 percent of reviewed claims met the coverage criteria for the K0011 power wheelchair.**

Insufficient documentation prevented the medical reviewer from determining whether an additional 11 percent of reviewed claims met the coverage criteria for K0011 power wheelchairs. In CY 2001, Medicare and its beneficiaries paid an estimated \$34 million for these claims. In half of these cases, the medical record did not provide a clear description of the beneficiaries' ambulatory or functional status. In other cases, it was clear that the beneficiary was bed or chair confined, but there was not enough information to determine whether programmable controls were necessary.

**For over half of K0011 claims, CMNs and/or delivery documentation were missing, incomplete, or dated after the date of service.**

CMNs and/or delivery documentation for 52 percent of K0011 power wheelchair claims were missing, incomplete, or dated after the date of service on the claim. Some claims had one or more of these documentation problems. Typically, CMNs are submitted electronically to the DMERCs; therefore, original copies of CMNs are not reviewed unless DMERCs specifically request this information from the supplier on a pre- or post-pay basis. Similarly, suppliers are not required to submit proof of delivery with the initial claim for payment, and DMERCs only collect delivery documentation as part of a pre- or post-pay review.

**Five percent of power wheelchair claims did not have the required supporting documentation.**

For 5 percent of K0011 power wheelchair claims, suppliers did not provide a CMN and/or proof of delivery. According to DMERC requirements, suppliers must maintain copies of signed CMNs and furnish them upon request. Suppliers must also maintain documentation showing that items were delivered to beneficiaries. If suppliers cannot provide this documentation, DMERCs can deny the claims and request overpayments. We estimate that Medicare and its beneficiaries paid an additional \$19 million in CY 2001 for K0011 claims that could not be substantiated by either a CMN or delivery documentation.

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**Even when suppliers did submit CMNs or proof of delivery, the documentation was often incomplete or dated after the date of service.**

Although DMERCs require that all elements contained on CMNs be completed, original paper CMNs obtained from suppliers for 20 percent of claims had at least one item missing. The supplier's National Supplier Clearinghouse number and the supplier's charge for the wheelchair were the items most often missing from CMNs.

In addition, CMNs for 13 percent of claims were dated after the service date. Almost one-quarter of these CMNs were dated more than a month after the date of service on the sample claim, with three CMNs dated almost a year after the date of service.

Although most suppliers submitted proof that power wheelchairs were delivered, delivery documentation supporting 29 percent of claims was missing one or more of the required elements. Quantity, serial number, and brand name of items delivered were the elements most often missing from delivery documents. In addition, delivery documentation for 5 percent of claims showed that the power wheelchair was delivered to the beneficiary after the date of service listed on the Medicare claim. In one case, the wheelchair was delivered 2 months after the supplier billed Medicare.

**Most responding beneficiaries reported using their power wheelchairs at home; other beneficiaries either do not use their power wheelchairs or use them for outside activities only.**

Sixty-eight percent of beneficiaries who responded to our survey (113 of 166) currently use their power wheelchairs inside their

homes. The wife of one beneficiary explained that the power wheelchair "is a necessary part of [her husband's] life. It's given him back a sense of mobility...It gave him back quality of life." Another beneficiary volunteered, "It's a wonderful invention, without it I would be crawling on the floor."

Although many beneficiaries offered positive comments about their wheelchairs and the sense of freedom they provide, 4 percent of respondents said that they have never used their power wheelchairs. One of these beneficiaries stated, "I don't need it yet...When my doctor approved it he said for later use. I am walking with a walker." Two other beneficiaries said that they never used their power wheelchairs because no one showed them how to use the equipment.

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An additional 12 percent of respondents said that they do not currently use their power wheelchairs but have used them in the past. Some of these beneficiaries no longer use their wheelchairs because the equipment is too big and heavy. One beneficiary stated, “It’s not the chair my doctor said I needed when they brought it out and I told them so...The wheelchair is too large and too fast...If I used it in my house I would tear up my furniture...I just don’t like it.” Other beneficiaries do not currently use their power wheelchairs due to unresolved maintenance problems, such as dead batteries or flat tires. One beneficiary said, “I haven’t had my chair since July 2002. The chair was picked up to be adjusted. I have contacted [the supplier] many, many times asking about my chair...I just keep getting the run around.” Another beneficiary reported, “The tires are flat...This is the second time the tires have gone flat...The supplier has been saying for months that they would pick up their chair but they have not.”

Another 12 percent of respondents reported that they currently use their power wheelchairs outside the home only. According to Section 1861(n) of the Social Security Act, a wheelchair must be needed for use in the home. Almost half of these beneficiaries indicated that they do not use their wheelchairs inside because the equipment is too large and does not fit in their homes. One respondent noted, “My apartment isn’t big enough. I use it when I go out like for a baby shower or to see my grandkids play baseball.” Another beneficiary said, “I wanted a smaller model.”

### **Many beneficiaries who completed our survey responded to suppliers’ direct marketing practices.**

Almost one-quarter of beneficiaries who responded to our survey learned about their power wheelchair suppliers from a television

commercial. As one beneficiary explained, “I saw the commercial. They said it is free and I thought ‘why not.’ They were thrilled, I gave them my doctor’s fax number. I had it in 2 days.” However, this same beneficiary commented that the wheelchair she received was “not what I thought they advertised for.” Another beneficiary said, “I saw it on TV. They were advertising. I called the company up. They sent me a video. They got in touch with my doctor and he came back and said it was approved.” The beneficiary also noted, “If I knew what it cost I would not have gotten it. I would have gotten something cheaper. I had no idea how much it cost until I got the Medicare bill.” An additional

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9 percent of respondents chose their suppliers after receiving something in the mail. Four percent of respondents obtained their power wheelchairs from suppliers who visited their homes. One of these beneficiaries commented, “the door-to-door sales rep gave me \$50 for signing up and offered me \$50 for referrals.”



## ‡ R E C O M M E N D A T I O N

A power wheelchair can greatly improve the quality of life for an individual who otherwise suffers from limited mobility. However, our coverage review indicates that Medicare and its beneficiaries spent an estimated \$178 million in 2001 for K0011 power wheelchairs that did not meet Medicare's coverage criteria. These inappropriate payments waste taxpayer dollars that could otherwise fund appropriate equipment for needy Medicare beneficiaries.

CMS has recognized the dramatic growth in payment for and utilization of power wheelchairs and is currently taking steps to address these issues as part of its 10-point plan of action to curb power wheelchair fraud, waste, and abuse. In fact, CMS has already begun implementing some of the options listed in the following recommendation. We believe that continued attention to Medicare payments for K0011 power wheelchairs is warranted.

**We recommend that CMS improve compliance with Medicare's coverage criteria for K0011 power wheelchairs.** CMS should consider the following options in order to improve compliance:

Require DMERCs to revise the coverage policy for K0011 power wheelchairs to include specific information about the medical conditions for which Medicare will cover this item. Our findings show that many beneficiaries did not meet coverage criteria for the K0011 power wheelchair but may have qualified for a lower-priced power wheelchair, a scooter, or a manual wheelchair. Given that patients frequently received K0011 power wheelchairs when their conditions warranted a lower level of equipment, CMS should evaluate the medical conditions and functional abilities that are associated with different types of mobility aids and describe these conditions/abilities in the coverage policies. This will ensure that beneficiaries have access to the equipment that is most appropriate for their conditions. DMERCs should also consider removing guidelines regarding the specialties of physicians who order scooters. In addition, DMERCs should require that physicians treat the patients for whom they order equipment.

Require DMERCs to conduct frequent reviews of the K0011 procedure code to ensure appropriate payments. When performing reviews of K0011 claims, DMERCs should ensure that suppliers have complete and thorough documentation. DMERCs should also request medical records from ordering physicians in addition to supporting documentation from suppliers. DMERCs should also consider routinely contacting

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beneficiaries during the course of reviews to ensure that the equipment provided by suppliers is appropriate for and useful to beneficiaries.

Educate ordering providers about Medicare's coverage criteria for different types of assistive devices, including power wheelchairs, manual wheelchairs, and scooters. Ordering providers play a key role in determining the need for and utilization of equipment billed to Medicare. According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, payment may not be made for power wheelchairs unless a physician, physician's assistant, nurse practitioner, or clinical nurse specialist has conducted a face-to-face examination of the patient and written a prescription for the item. CMS relies on the clinical judgment of these health care professionals to ensure that Medicare only pays for items that are most appropriate for beneficiaries. However, ordering providers may not be aware of Medicare's coverage requirements for mobility devices. A lack of provider education about Medicare's coverage criteria for wheelchairs could adversely affect physicians' ability to make informed decisions about the types of mobility devices that are best for their patients, which could ultimately lead to inappropriate Medicare payments.

Educate Medicare beneficiaries about coverage criteria for wheelchairs and scooters. Beneficiaries also play a key role in ensuring that Medicare does not pay for medically unnecessary or unused items. Beneficiaries who are knowledgeable about Medicare's coverage guidelines can make more informed choices about the assistive devices that would meet both their own needs and Medicare's coverage requirements.

### **Agency Comments**

CMS concurred with our recommendation and agreed with our suggestions regarding coverage policy revisions and provider and beneficiary education. They also agreed that more frequent reviews of the K0011 code will help ensure appropriate payments; however, they do not believe that routinely contacting beneficiaries would yield meaningful results. CMS confirmed that they have already begun implementing many of our report recommendations through their power wheelchairs workgroup, which was established to develop a plan of action to ensure that payments are only made for power wheelchairs that are reasonable and necessary. Specific actions by CMS include: requiring DMERCs to develop a complete picture of a patient's medical condition before making medical review coverage determinations; developing a regulation to remove the current requirement that scooters

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be prescribed only by certain specialists; and developing a regulation that requires a face-to-face examination by the treating physician prior to ordering a power wheelchair. CMS is also poised to release an educational campaign designed to provide both physicians and beneficiaries with needed information regarding Medicare and DMERC coverage policy. The full text of CMS's comments is presented in Appendix B.

‡ A P P E N D I X ~ A

**Table 1. Estimates and Confidence Intervals**

	<b>Point Estimate</b>	<b>95 % Confidence Interval</b>
Claims That Did Not Meet K0011 Coverage Criteria But May Have Met Criteria For Another Item	44.78%	38.35% - 51.21%
Excessive Medicare Allowances in 2001 for Claims That Did Not Meet K0011 Coverage Criteria But May Have Met Criteria for Another Item	\$82,274,760	\$68,472,518 - \$96,077,002
Claims That Did Not Meet K0011 Coverage Criteria But Would Have Qualified For K0010	8.26%	4.70% - 11.82%
Claims That Did Not Meet K0011 Coverage Criteria And Reviewer Could Not Determine If Another Item Would Have Been Appropriate	10.87%	6.85% - 14.89%
Total Medicare Allowances in 2001 for Claims that Met K0011 Coverage Criteria	\$38,288,606	\$25,217,076 - \$51,360, 135
Total Medicare Allowances in 2001 for Claims Where Reviewer Could Not Determine Whether K0011 Coverage Criteria Were Met	\$34,117,123	\$21,722,810 - \$46,511,437
Claims Without CMNs or Delivery Documentation	5.30%	2.69% - 7.91%
Claims With CMNs With At Least One Item Missing	19.63%	14.89% - 24.37%
Claims With CMNs Dated After Date of Service That Were Dated More Than a Month After Date of Service	23.53%	9.08% - 37.97%
Claims With Delivery Documentation Dated After Date of Service	4.83%	2.27% - 7.40%

Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** MAR 23 2004

**TO:** Dara Corrigan  
Acting Principal Deputy Inspector General

**FROM:** Dennis G. Smith *Dennis G. Smith*  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: *Medicare Payments for Power Wheelchairs* (OEI-03-02-00600)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to respond to the Office of Inspector General's (OIG) draft report: *Medicare Payments for Power Wheelchairs* (OEI-03-02-00600). CMS believes this report will make a valuable contribution to efforts to ensure that Medicare pays only for items and services that meet eligibility criteria set out in the Medicare law and Federal regulations.

Power wheelchairs and power scooters are covered items under the durable medical equipment (DME) benefit. By law, DME must be medically necessary for use in the home. Therefore, if a beneficiary can get around in the home using a walker, a traditional wheelchair, or other aid to mobility, the beneficiary is not eligible under the standards established by Congress for a power wheelchair or scooter.

In the past 3 years, Medicare claims for power wheelchairs and scooters have increased dramatically; largely, CMS believes, in response to aggressive direct-to-consumer advertising, coupled with a lack of understanding on the part of prescribing physicians of the criteria for coverage of these vehicles. In some cases, the wheelchair is ordered not by the beneficiary's treating physician, but by a physician who sees the beneficiary solely for the purpose of signing the required Certificate of Medical Necessity.

Growth in Medicare spending for this product has greatly outpaced all other spending and economic growth indicators over the past 3 years. In 2003, Medicare was on target to spend over \$1.2 billion on power wheelchairs alone. The most dramatic growth has been in claims for standard weight frame, motorized/power wheelchairs with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking (coded as K0011 on claim forms). Each of these wheelchairs costs over \$5000, of which Medicare pays 80 percent; the beneficiary's co-payments cover the remaining 20 percent.

Making appropriate payments for power wheelchairs is an urgent priority for CMS, which has established a workgroup to identify potential causes of this growth and to develop a plan of action to ensure that payments are only made for power wheelchairs when their intended uses are reasonable and necessary. This workgroup identified opportunities to improve operations in:

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provider enrollment, policy, medical review, fraud detection, and education. CMS has implemented many of the recommendations in the subject report through its workgroup. Our detailed comments on the OIG recommendations follow.

OIG Recommendation

The CMS should require durable medical equipment regional carriers (DMERCs) to revise coverage policy for K0011 power wheelchairs to include: 1) specific information about the medical conditions for which Medicare will cover this item; 2) relaxing the requirements for who can prescribe scooters; and 3) requiring physicians treat the patients for whom they order equipment.

CMS Response

We agree that describing the medical conditions under which coverage will be granted will result in increased compliance with coverage rules. In fact, for some time, the DMERCs have been required to develop a complete picture of the patient's medical condition before making coverage determinations through medical review of claims.

We concur with the need to relax the prescribing requirements for scooters. CMS is currently developing a regulation that will remove the current requirement that scooters be prescribed only by certain specialists.

We also concur with the need for physicians to treat patients for whom they order equipment. CMS is currently developing a regulation to implement section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that will require a face-to-face examination by the treating physician prior to ordering a power wheelchair.

OIG Recommendation

The CMS should require DMERCs to conduct frequent reviews of the K0011 procedure code to ensure appropriate payments, including requesting documentation from physicians and "routinely" contacting beneficiaries during the course of review.

CMS Response

The CMS agrees that more frequent review of the K0011 procedure code will help ensure appropriate payments. Operation Wheeler Dealer requires the DMERCs to develop and implement a consistent medical review strategy to combat wheelchair abuse.

We also agree that requesting documentation from physicians may be useful. The CMS Program Integrity Manual allows DMERCs to request documentation from ordering physicians concurrently with a request for documentation made to the supplier of the item.

However, CMS disagrees that "routinely" contacting beneficiaries would provide meaningful results. We do not believe that the burden placed on beneficiaries and on the DMERCs by

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“routinely” contacting beneficiaries would be outweighed by any benefits accrued. Historically, when DMERCs contacted beneficiaries, responses were difficult to obtain, and were often inaccurate.

OIG Recommendation

The CMS should educate ordering providers about Medicare’s coverage criteria for different types of assistive devices, including power wheelchairs, and scooters.

CMS Response

We concur. CMS is poised to release an educational campaign designed to provide physicians with needed information regarding Medicare and DMERC coverage policy.

OIG Recommendation

The CMS should educate Medicare beneficiaries about coverage criteria for wheelchairs and scooters.

CMS Response

We concur. CMS is poised to release an educational campaign designed to provide beneficiaries with needed information regarding Medicare and DMERC coverage policy.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises.

Attachment

## ‡ A C K N O W L E D G E M E N T S

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia Regional Office, and Linda M. Ragone, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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