Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE IMPROPERLY PAID DURABLE MEDICAL EQUIPMENT SUPPLIERS AN ESTIMATED $8 MILLION OF THE $40 MILLION PAID FOR POWER MOBILITY DEVICE REPAIRS

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Office of Inspector General

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Report in Brief
Date: May 2022
Report No. A-09-20-03016

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Improperly Paid Durable Medical Equipment Suppliers an Estimated $8 Million of the $40 Million Paid for Power Mobility Device Repairs

Why OIG Did This Audit

From October 1, 2018, through September 30, 2019 (audit period), Medicare Part B paid approximately $40.1 million for Power Mobility Device (PMD) repairs for Medicare beneficiaries nationwide. For 2006 through 2008, a prior OIG review of claims for capped rental durable medical equipment (DME), which includes certain PMDs, found that Medicare paid DME suppliers (suppliers) approximately $26.8 million for DME repair claims that did not meet Medicare requirements.

We conducted this nationwide audit of PMD repairs to determine whether the issues identified in the prior OIG report were still occurring during our audit period.

Our objective was to determine whether suppliers complied with Medicare requirements when billing for PMD repairs.

How OIG Did This Audit

Our audit covered Medicare Part B paid claims for 37,013 beneficiaries for whom suppliers submitted charges for 244,667 claim lines, totaling $40.1 million, for PMD repairs provided during our audit period. The beneficiary coinsurance associated with these PMD repairs totaled $10.4 million. (A claim line represented one PMD repair for a beneficiary on a single date of service.) We selected a stratified random sample of 100 beneficiaries, for whom 52 suppliers submitted charges for 922 PMD repairs totaling $170,776.

What OIG Found

Not all suppliers complied with Medicare requirements when billing for PMD repairs. For 637 of the 922 PMD repairs associated with the 100 sampled beneficiaries, suppliers complied with those requirements. However, for 261 PMD repairs, suppliers submitted PMD repair charges that did not comply with those requirements. (We did not review the remaining 24 PMD repairs but treated them as non-errors because they were under contractor review.) Specifically, documentation did not adequately support the charges for PMD repairs, the labor time associated with PMD repairs was not documented, or PMD repair charges were not reasonable and necessary, resulting in $41,137 in improper Medicare payments and $10,494 in associated beneficiary coinsurance payments. We also identified questionable charges for 183 PMD repairs associated with 19 sampled beneficiaries. Although the billing of these PMD repairs did not reflect noncompliance with Medicare requirements, suppliers did not meet documentation standards established by guidance or submitted charges that may not have been reasonable and necessary, resulting in $20,692 in questionable Medicare payments and $5,278 in associated beneficiary coinsurance payments.

On the basis of our sample results, we estimated that $7.9 million of the $40.1 million paid for PMD repairs was improperly paid. We also estimated that Medicare could have saved as much as an additional $3.7 million for questionably paid PMD repairs. In addition, we estimated that Medicare beneficiaries could have saved as much as $3 million in coinsurance for the improperly and questionably paid PMD repairs.

What OIG Recommends and CMS Comments

We recommend that the Centers for Medicare & Medicaid Services (CMS) instruct the DME Medicare contractors to: (1) recover $41,137 in overpayments for PMD repairs; (2) notify suppliers to refund $10,494 in coinsurance; and (3) based upon the results of this audit, notify appropriate suppliers so that they can exercise reasonable diligence to identify, report, and return any overpayments. We also made four procedural recommendations. The full text of our recommendations is shown in the report.

CMS concurred with five of our seven recommendations, including two procedural recommendations. However, CMS did not concur with one procedural recommendation and did not concur with one part of another procedural recommendation. After reviewing CMS's comments, we maintain that our recommendations are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

From October 1, 2018, through September 30, 2019 (audit period), Medicare Part B paid approximately $40.1 million for Power Mobility Device (PMD) repairs, including replacement parts needed to repair PMDs for Medicare beneficiaries nationwide. For 2006 through 2008, a prior Office of Inspector General (OIG) review of claims for capped rental durable medical equipment (DME), which includes certain PMDs, found that Medicare paid DME suppliers (suppliers) approximately $26.8 million for DME repair claims that did not meet Medicare requirements.[1]

We conducted this nationwide audit of PMD repairs to determine whether the issues identified in the prior OIG report were still occurring during our audit period.

OBJECTIVE

Our objective was to determine whether suppliers complied with Medicare requirements when billing for PMD repairs.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B provides supplementary medical insurance for medical and other health services, including DME. CMS contracted with two DME Medicare administrative contractors (DME MACs) to process and pay Medicare Part B claims for the four DME jurisdictions (A, B, C, and D), which include specific States and territories.[2] Suppliers must submit claims to the DME MAC that serves the State or territory in which a Medicare beneficiary permanently resides.

The DME MACs help CMS in its effort to prevent and detect improper payments and promote Medicare compliance. DME MAC responsibilities include educating suppliers on Medicare

[1] *A Review of Claims for Capped Rental Durable Medical Equipment* (OEI-07-08-00550), issued August 2010. Capped rental DME is a specific category of DME for which Medicare pays an amount that is capped after 13 consecutive months of rental to a beneficiary and the ownership of the equipment transfers to the beneficiary after the 13th month.

[2] Each DME MAC processes claims for two of the four jurisdictions. Each Medicare Part B claim contains details regarding each provided service or item that is billed to Medicare.

requirements and billing procedures and applying system edits to claims to determine whether the claims are complete and should be paid.[3]

Medicare Coverage of Power Mobility Devices

Medicare covers the rental and purchase of PMDs, accessories to PMDs, and repairs of PMDs.

Rental and Purchase of Power Mobility Devices

Figure 1: Types of PMDs

Medicare Part B covers DME, including the rental or purchase of PMDs. PMDs consist of power wheelchairs and power-operated vehicles (POVs). (See Figure 1.) A power wheelchair is a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction. A POV is a three- or four-wheeled motorized scooter that is operated by a tiller (i.e., a steering mechanism with handlebars).[4] For a PMD to be covered by Medicare, a beneficiary must have a medical need for the PMD in the home.[5]

Medicare pays for the rental of power wheelchairs. After a beneficiary has rented a power wheelchair for a 13-month period, the supplier must transfer ownership of the power wheelchair to the beneficiary at no additional cost. Medicare also pays for the rental or purchase of POVs.[6] If the rental option is selected, the supplier retains ownership of the POV, and Medicare limits the total rental payments to the purchase price.[7]

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[3] An edit is programming within the standard claims processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

[4] 42 CFR §§ 410.38(a) and (c)(6).

[5] The Social Security Act (the Act) § 1861(n).

[6] The beneficiary has the option to rent or purchase the POV at the time the supplier furnishes the POV. This purchase option is also available for complex rehabilitative power wheelchairs.

[7] The Act § 1861(n); 42 CFR §§ 414.210(a) and (b)(1); 42 CFR § 414.220(b).

Accessories to Power Mobility Devices

Medicare Part B covers PMD accessories (i.e., parts that may be added to PMDs) that are reasonable and necessary to manage beneficiaries' medical needs.[8] Examples of PMD accessories include: (1) an elevating leg rest, which helps aide the beneficiary to elevate the legs and flex or extend the knee; and (2) a swing-away remote joystick mount, which allows the joystick to swing in and out, enabling the beneficiary to get on and off the PMD.

Repairs of Power Mobility Devices

Suppliers are required to maintain and repair rented PMDs at no charge to Medicare or to beneficiaries.[9] Medicare Part B covers repairs of beneficiary-owned PMDs when the repairs are necessary to make the PMD serviceable. Medicare pays for the labor associated with the repairs and for necessary replacement parts (e.g., tires, batteries, and joysticks). To bill for labor for a PMD repair, a supplier includes on the claim Healthcare Common Procedure Coding System (HCPCS) code K0739 using the appropriate number of units representing 15-minute increments.[10] A supplier may also bill Medicare for a loaner PMD provided to a beneficiary while a repair is being conducted.[11]

Medicare Requirements and Guidance for Repairs of Power Mobility Devices

Suppliers that perform PMD repairs must follow Medicare's statutory and regulatory requirements and ensure that charges (i.e., billed services paid by Medicare) for PMD repairs are reasonable and necessary.[12, 13] Suppliers are also expected to follow CMS and DME MAC

[8] The Act §§ 1834(a)(7)(A)(iv), 1861(n) and (s)(6), and 1862(a)(1)(A); Local Coverage Determination (LCD): Wheelchair Options and Accessories (LCD L33792). LCDs are determinations made by a DME MAC whether to cover a particular item or service in a DME MAC's jurisdiction. The LCD related to PMD accessories is used by both DME MACs and covers all four DME jurisdictions.

[9] The Act § 1834(a)(11)(A); 42 CFR §§ 414.210(e)(1) and 424.57(c)(14). Medicare does not pay for repairs of rented PMDs.

[10] HCPCS codes are a collection of standardized codes that represent medical procedures, supplies, products, and repairs. These codes are used to facilitate Medicare's processing of health insurance claims.

[11] One month's rental of a PMD is covered if a beneficiary-owned PMD is being repaired (LCD: Power Mobility Devices (LCD L33789)). This LCD is used by both DME MACs and covers all four DME jurisdictions.

[12] In this report, the term "charges" refers to the Medicare payment amount rather than the charges submitted by the supplier. Not all charges that the supplier submits are paid by Medicare.

[13] CMS also considers National Coverage Determinations (NCDs) and LCDs to be Medicare requirements. CMS develops NCDs and DME MACs develop LCDs through an evidence-based process, with opportunities for the public to participate and comment.

guidance, which include documentation standards that specify documentation that suppliers are expected to have on file to support claims for PMD repairs.[14]

CMS guidance documents, such as CMS's *Medicare Program Integrity Manual* and *Medicare Benefit Policy Manual*, are designed to educate suppliers on Medicare requirements and to assist contractors in implementing those requirements. CMS also uses these documents to clarify Medicare requirements. Guidance documents include Local Coverage Articles (LCAs), which are issued by the DME MACs.[15]

Medicare Requirements in Federal Laws and Regulations

For beneficiary-owned PMDs, Medicare covers reasonable and necessary charges for repairs and nonroutine maintenance and servicing that are necessary to make beneficiary-owned PMDs serviceable. Reasonable and necessary charges are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. PMD repairs must be appropriately and sufficiently documented to support the claim for these services.[16]

If a DME MAC determines that a power wheelchair will not last for the entire reasonable useful lifetime of 5 years (5-year RUL), the supplier that transferred ownership of the power wheelchair to the beneficiary is responsible for furnishing a replacement power wheelchair at no cost to the beneficiary or the Medicare program. In making this determination, the DME MAC may consider whether the accumulated costs of repairs exceed 60 percent of the cost to replace the power wheelchair.[17]

CMS and DME MAC Guidance

CMS guidance states that if the expense for a PMD repair exceeds the estimated expense of purchasing or renting another PMD for the remaining period of medical need, no payment can be made for the amount of the excess.[18]

CMS and DME MAC guidance on documentation standards states that: (1) either the treating practitioner or the supplier must document that a PMD repair itself was reasonable and necessary and (2) the supplier must maintain detailed records describing the need for and

[14] CMS considers documentation standards for PMD repairs as guidance rather than as Medicare requirements. We did not use documentation standards for purposes of determining overpayments.

[15] DME MACs develop and issue LCAs, which generally contain billing, coding, or other guidance that complement LCDs. CMS considers LCAs as guidance rather than as Medicare requirements.

[16] The Act §§ 1833(e) and 1834(a)(7)(A)(iv); 42 CFR § 414.210(e)(1).

[17] 42 CFR §§ 414.210(e)(4) and (f)(1). The requirement identified in 42 CFR section 414.210(e)(4) does not apply to POVs.

[18] CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, § 110.2.

nature of all repairs.[19] In addition, CMS guidance states that the DME MAC must ensure that a supplier's records include the nature of the repair required and work performed to restore the item to its functionality to meet the Medicare beneficiary's medical need.[20] DME MAC guidance also states that the supplier must maintain detailed records for repairs, including the labor time to restore the item to its functionality.[21]

Furthermore, CMS and DME MAC guidance on documentation standards states that a supplier must have documentation from the physician or treating practitioner that indicates the PMD being repaired continues to be reasonable and necessary.[22]

Prior Office of Inspector General Work

A prior OIG review of claims for capped rental DME, which includes power wheelchairs, found that Medicare paid suppliers approximately $26.8 million for routine maintenance and servicing of equipment, repairs of rented equipment, and other repairs that did not meet Medicare requirements (e.g., equipment was still covered under warranty or the supplier did not provide support for medical necessity, the service provided, and delivery of the DME).[23] This review also found that Medicare paid suppliers approximately $29 million for questionable claims: (1) for repairs that exceeded 60 percent of the purchase price of new equipment and (2) for which the supplier did not provide valid serial numbers for repaired equipment.[24]

Prior OIG audits also found that suppliers received improper payments for PMDs that did not meet Medicare requirements. For example, suppliers did not provide OIG with: (1) support of the medical necessity of PMDs, (2) sufficient supporting documentation, and (3) properly completed physician orders. (See Appendix B for a list of related OIG reports.)

Medicare Requirements for Suppliers To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, suppliers must exercise

[19] LCA: *Standard Documentation Requirements for All Claims Submitted to DME MACs* (LCA A55426) and CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 5, § 5.10.1. (During our audit period, this provision was found at section 5.8.1.)

[20] CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 5, § 5.10.1.

[21] LCA A55426.

[22] CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 5, § 5.10.1; LCA A55426.

[23] Capped rental DME is a specific category of DME for which Medicare pays an amount that is capped after 13 consecutive months of rental to a beneficiary and the ownership of the equipment transfers to the beneficiary after the 13th month.

[24] *A Review of Claims for Capped Rental Durable Medical Equipment* (OEI-07-08-00550), issued August 2010.

reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Suppliers must report and return any identified overpayments by the later of: (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[25]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, suppliers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[26]

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B paid claims for 37,013 beneficiaries for whom suppliers submitted charges for 244,667 claim lines, totaling $40.1 million, for PMD repairs provided during our audit period. The beneficiary coinsurance associated with these PMD repairs totaled $10.4 million.[27] A claim line represented one PMD repair for a beneficiary on a single date of service. (We refer to these claim lines as "PMD repairs" throughout the report.[28]) We grouped the claim lines by beneficiary and included in the sampling frame beneficiaries associated with PMD repair charges that totaled $150 or more. We selected a stratified random sample of 100 beneficiaries, for whom 52 suppliers submitted charges for 922 PMD repairs totaling $170,776.

Suppliers provided us with supporting documentation for the sampled beneficiaries. Many suppliers also provided medical records to support the PMD repairs in our sample. However, for some sampled beneficiaries, suppliers were unable to provide medical records. In those cases, we requested the medical records directly from the treating physicians. We reviewed the documentation to determine whether the suppliers complied with Medicare requirements when billing for PMD repairs; however, we did not determine whether the PMDs were medically necessary.

We categorized our audit findings into those that were and were not based on Medicare requirements. Medicare payments made to suppliers for PMD repairs that did not comply with

[25] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

[26] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

[27] Medicare requires beneficiaries to pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare for PMD repairs and pays the supplier the remaining 80 percent. However, not all beneficiaries pay out-of-pocket for coinsurance. Some beneficiaries have secondary insurance coverage (e.g., Medicaid) that will pay the coinsurance.

[28] PMD repairs include claim lines for labor, parts that were replaced, and loaner PMDs provided to beneficiaries while the PMD repairs were being made.

Medicare requirements were considered improper payments. Medicare payments made to suppliers for PMD repairs for which the suppliers did not comply with documentation standards established by guidance or for which the charges may not have been reasonable and necessary were considered questionable payments, which Medicare could potentially have avoided.

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

Appendix A describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

Not all suppliers complied with Medicare requirements when billing for PMD repairs. For 637 of the 922 PMD repairs associated with the 100 sampled beneficiaries, suppliers complied with Medicare requirements. However, for 261 PMD repairs associated with 76 sampled beneficiaries, suppliers submitted PMD repair charges that did not comply with those requirements.[29] Specifically, documentation did not adequately support the charges for PMD repairs, the labor time associated with PMD repairs was not documented, or PMD repair charges were not reasonable and necessary, resulting in $41,137 in improper Medicare payments and $10,494 in associated beneficiary coinsurance payments. These improper payments occurred because the DME MACs' oversight was not adequate to ensure that suppliers complied with Medicare requirements when billing for PMD repairs.

We also identified questionable charges for 183 PMD repairs associated with 19 sampled beneficiaries. Although the billing of these PMD repairs did not reflect noncompliance with Medicare requirements, suppliers did not meet documentation standards established by guidance or submitted charges that may not have been reasonable and necessary, resulting in $20,692 in questionable Medicare payments and $5,278 in associated beneficiary coinsurance payments.[30] These questionable payments occurred because CMS did not have adequate Medicare requirements to prevent suppliers from submitting questionable PMD repair charges.

[29] We did not review 24 PMD repairs associated with 4 sampled beneficiaries but treated them as non-errors because they were under review by a CMS contractor after we had selected our sample. The 637 PMD repairs for which suppliers complied with Medicare requirements were associated with 94 sampled beneficiaries. The total number of sampled beneficiaries exceeds 100 because suppliers complied with requirements for some but not all repairs for 72 sampled beneficiaries. For each sampled beneficiary, we disallowed only the amounts paid for the PMD repairs that did not comply with Medicare requirements.

[30] Seventy-five PMD repairs were considered both improperly and questionably paid. However, the $20,692 in questionable Medicare payments was in addition to the $41,137 in improper Medicare payments.

On the basis of our sample results, we estimated that $7.9 million of the $40.1 million paid for PMD repairs was improperly paid.[31] We also estimated that Medicare could have saved as much as an additional $3.7 million for questionably paid PMD repairs.[32] In addition, we estimated that Medicare beneficiaries could have saved as much as $3 million in coinsurance for the improperly and questionably paid PMD repairs.[33]

SUPPLIERS SUBMITTED POWER MOBILITY DEVICE REPAIR CHARGES THAT DID NOT COMPLY WITH MEDICARE REQUIREMENTS

For 261 PMD repairs associated with 76 sampled beneficiaries, suppliers submitted charges for the repairs that did not comply with Medicare requirements. Specifically, documentation did not adequately support the charges for PMD repairs (for 155 PMD repairs associated with 36 sampled beneficiaries), labor time associated with PMD repairs was not documented (for 103 PMD repairs associated with 65 sampled beneficiaries), and PMD repair charges were not reasonable and necessary (for 45 PMD repairs associated with 13 sampled beneficiaries).[34] Improper payments for these repairs occurred because the DME MACs' oversight was not adequate to ensure that suppliers complied with Medicare requirements when billing for PMD repairs.

Medicare Requirements

Medicare payments must not be made to a supplier for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (Social Security Act § 1833(e)).

Medicare pays the reasonable and necessary charges for maintenance and servicing of beneficiary-owned DME (42 CFR § 414.210(e)(1)).

HCPCS code K0739 is used to bill for the "repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes" (American Medical Association, *HCPCS Level II*, 2018–2019).

[31] The estimated improper Medicare payment amount was $7,948,182.

[32] The estimated Medicare savings amount was $3,739,346.

[33] The estimated beneficiary coinsurance savings amount was $2,981,525.

[34] The total number of improperly paid repairs exceeds 261 because suppliers for 42 PMD repairs did not comply with more than 1 Medicare requirement. In addition, the total number of sampled beneficiaries exceeds 76 because 32 sampled beneficiaries had more than 1 improperly paid PMD repair.

Documentation Did Not Adequately Support Power Mobility Device Repair Charges

For 155 PMD repairs associated with 36 sampled beneficiaries, suppliers' documentation did not adequately support the charges for these repairs. Specifically, the suppliers did not furnish documentation to support that the PMD repairs were performed or that they were necessary.

For example, one supplier submitted charges for PMD repairs made to a sampled beneficiary's power wheelchair and received $3,568 in Medicare payments. This supplier provided only documentation that listed the HCPCS codes for each of the nine PMD repairs billed. The supplier did not provide any documentation to describe the PMD repairs or why the repairs were necessary.

Labor Time Associated With Power Mobility Device Repairs Was Not Documented

For 103 PMD repairs associated with 65 sampled beneficiaries, suppliers used HCPCS code K0739 to bill for the labor time associated with the repairs, but these suppliers did not have any documentation to support the time billed.

For example, 1 supplier submitted charges for 45 hours of labor time for 24 PMD repairs associated with 17 sampled beneficiaries and received $2,407 in Medicare payments. This supplier did not provide documentation for the time it billed for these repairs and stated that it did not keep detailed records for individual PMD repairs because technicians worked on multiple repairs at the same time.

Power Mobility Device Repair Charges Were Not Reasonable and Necessary

For 45 PMD repairs associated with 13 sampled beneficiaries, suppliers submitted charges that were not reasonable and necessary for PMD repairs with the same date of service that exceeded the estimated cost to replace the PMDs.[35]

In one example, a supplier submitted charges for PMD repairs made to a sampled beneficiary's power wheelchair and received $3,123 in Medicare payments. At the time of the repairs, the replacement cost of the PMD was $1,494. Therefore, we disallowed $1,629, which was the portion of the Medicare payment that exceeded the replacement cost.

In another example, a supplier submitted charges for PMD repairs made to a sampled beneficiary's power wheelchair on two separate occasions in 1 month and received $1,741 and $1,625 in Medicare payments. At the time of the repairs, the replacement cost of the PMD was $1,523. Therefore, we disallowed the portion of the Medicare payments that exceeded the

[35] CMS confirmed that the Federal regulation (42 CFR § 414.210(e)(1)) would support a finding that questioned the amount paid for PMD repairs that exceeded the estimated cost to replace a PMD. To be conservative, we used the fee schedule applicable to our audit period to calculate the cost to replace a PMD and its required accessories (i.e., those that were prescribed with the PMD).

cost to replace the PMD on each date of service, which was $218 and $102, respectively. On each occasion, the supplier billed for repairs that exceeded the PMD's replacement cost.

DME MACs' Oversight Was Not Adequate To Ensure That Suppliers Complied With Medicare Requirements

Improper payments occurred because the DME MACs' oversight was not adequate to ensure that suppliers complied with Medicare requirements when billing for PMD repairs. The DME MACs stated that, during our audit period, they reviewed claims data to determine whether PMD repairs associated with certain HCPCS codes should be paid.[36] However, the DME MACs did not have oversight mechanisms, such as system edits, that applied to all PMD repairs. Therefore, the DME MACs did not always identify PMD repair charges that may have been excessive or that may have exceeded the estimated cost to replace the PMDs being repaired. In addition, DME MACs did not review supplier documentation to verify that suppliers had complied with Medicare requirements when billing for PMD repairs. If the DME MACs do not take action to improve their oversight, Medicare and its beneficiaries will continue to make improper payments to suppliers for unnecessary repairs.

To educate suppliers that bill for PMD repairs, the DME MACs conducted webinars on general Medicare requirements and provided educational material and guidance on their websites. However, the DME MACs' educational material did not explain that labor time should be documented to support that the time billed was the actual time spent on repairs.[37] In addition, many suppliers were not aware that they had to maintain documentation to support the labor time billed for PMD repairs. Because the HCPCS code that suppliers used to bill for labor time (K0739) is based on the time spent on PMD repairs, suppliers must have documentation to support the amount of time spent on each PMD repair billed to Medicare.

SUPPLIERS SUBMITTED QUESTIONABLE CHARGES FOR POWER MOBILITY DEVICE REPAIRS

Suppliers submitted questionable charges for 183 PMD repairs associated with 19 sampled beneficiaries. These charges are questionable because suppliers did not meet documentation standards established by Medicare guidance (for 126 PMD repairs associated with 11 sampled beneficiaries), and PMD repair charges may not have been reasonable and necessary (for

[36] The DME MACs stated that they reviewed claims data for the HCPCS codes for miscellaneous PMD parts and HCPCS codes that require a narrative statement from the supplier.

[37] Medicare payments must not be made to a supplier for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)). The supplier must maintain detailed records for repairs, including the labor time to restore the item to its functionality (LCA A55426).

65 PMD repairs associated with 9 sampled beneficiaries).[38] CMS did not have adequate Medicare requirements to prevent suppliers from submitting questionable PMD repair charges.

Medicare Requirements and Guidance

Medicare pays the reasonable and necessary charges for maintenance and servicing of beneficiary-owned equipment. Reasonable and necessary charges are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. (42 CFR § 414.210(e)(1).)

A supplier that transfers ownership of a power wheelchair to a beneficiary is responsible for furnishing a replacement power wheelchair at no cost to the beneficiary or the Medicare program if the DME MAC determines that the power wheelchair furnished by the supplier will not last for the entire 5-year RUL. In making this determination, the DME MAC may consider whether the accumulated costs of repair exceed 60 percent of the cost to replace the power wheelchair (42 CFR §§ 414.210(e)(4) and (f)(1)).[39]

Medicare guidance states that when reviewing a claim for a PMD repair, the DME MAC must review supplier documentation to verify that the item continues to be medically necessary and that the PMD repair was necessary. For example, documentation from the physician or treating practitioner must indicate that the wheelchair being repaired continues to be medically necessary. Documentation is considered timely when it is on record within the preceding 12 months from the date of PMD repair. (CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 5, § 5.10.1.)[40]

DME MAC guidance states that for a PMD repair to be reimbursed, Medicare requires that the treating physician document that the PMD being repaired continues to be reasonable and necessary (e.g., there is timely documentation in the beneficiary's medical record showing usage of the PMD). Timely documentation is defined as a record in the preceding 12 months from the date of the PMD repair. (LCA A55426.)[41]

[38] The total number of PMD repairs exceeds 183 because suppliers for 8 PMD repairs did not meet documentation standards established by Medicare guidance and submitted charges that may not have been reasonable and necessary. In addition, the total number of sampled beneficiaries exceeds 19 because 1 sampled beneficiary had more than 1 PMD repair that was questionably paid.

[39] The requirement identified in 42 CFR section 414.210(e)(4) does not apply to POVs.

[40] CMS considers the *Medicare Program Integrity Manual* as guidance rather than as Medicare requirements. We did not use CMS's *Medicare Program Integrity Manual* for the purpose of determining whether there was an overpayment.

[41] CMS considers LCA A55426 as guidance rather than as Medicare requirements. We did not use LCA A55426 for the purpose of determining whether there was an overpayment.

Suppliers Did Not Meet Documentation Standards Established by Guidance

For 126 PMD repairs associated with 11 sampled beneficiaries, suppliers did not meet documentation standards established by guidance, which required suppliers to provide timely documentation to support that the PMDs being repaired continued to be reasonable and necessary. We contacted the treating physicians to obtain medical records for these 11 sampled beneficiaries. However, six physicians could not be reached after multiple attempts; four physicians did not provide medical records that were dated within the preceding 12 months; and one physician provided medical records dated within the preceding 12 months, but the medical records did not support that the beneficiary continued to need the PMD.

For example, to document PMD repairs made to a sampled beneficiary's power wheelchair, one supplier provided a PMD repair order that the supplier created and the treating physician signed more than 3 years before the date of the first PMD repair in our sample (November 5, 2018).[42] When we contacted the treating physician, the physician stated that the most recent visit with the sampled beneficiary was May 17, 2017 (almost 18 months before the date of the first PMD repair in our sample) and was unable to provide timely documentation to support that the beneficiary continued to need the PMD. The supplier was paid $1,573 for the repairs made to this sampled beneficiary's wheelchair during our audit period. We considered the $1,573 to be questionable because neither the supplier nor the treating physician provided timely documentation to show that the beneficiary continued to need the wheelchair.

Power Mobility Device Repair Charges May Not Have Been Reasonable and Necessary

For 65 PMD repairs associated with 9 sampled beneficiaries, suppliers submitted charges for the repairs that may not have been reasonable and necessary:

- For 63 PMD repairs associated with 8 sampled beneficiaries, suppliers submitted repair charges for power wheelchairs that were within their 5-year RUL, and the accumulated costs of the repairs exceeded 100 percent of the cost to replace the power wheelchairs.

- For seven PMD repairs associated with three sampled beneficiaries, suppliers submitted charges for replacing PMD parts that had been replaced within the previous 12 months.

The total number of PMD repairs that may not have been reasonable and necessary exceeded 65 because suppliers submitted charges for 5 PMD repairs that had both of the issues above. The total number of sampled beneficiaries associated with these repairs exceeded nine because two sampled beneficiaries had PMD repairs with both of these issues.

[42] According to the Medicare claims data, when the PMD was provided, the sampled beneficiary had diagnoses of shortness of breath, unspecified joint disorder, feeling of discomfort and fatigue, and chronic airway obstruction. For the PMD repairs provided during our audit period, the Medicare claims data and the order signed by the treating physician indicated that the sampled beneficiary's primary diagnosis was arthropathy (i.e., a disease of the joints, such as arthritis).

Suppliers Submitted Repair Charges for Power Wheelchairs That Were Within Their 5-Year RUL, and the Accumulated Costs of Repairs Exceeded 100 Percent of the Replacement Cost

For 63 PMD repairs associated with 8 sampled beneficiaries, suppliers submitted charges for repairs made to power wheelchairs during the 5-year RUL after the total accumulated cost of repairing these power wheelchairs had exceeded the cost to replace them. For the power wheelchairs associated with the eight beneficiaries, Medicare paid $54,912 for repairs made during the 5-year RUL when the cost of replacing the power wheelchairs would have been $36,306. These excessive costs suggest that the power wheelchairs provided to these beneficiaries were not in adequate condition to have lasted for the entire 5-year RUL. If that was the case, the suppliers that transferred ownership of the power wheelchairs to these beneficiaries should have been responsible for furnishing replacement power wheelchairs at no cost to the beneficiaries or to Medicare.[43]

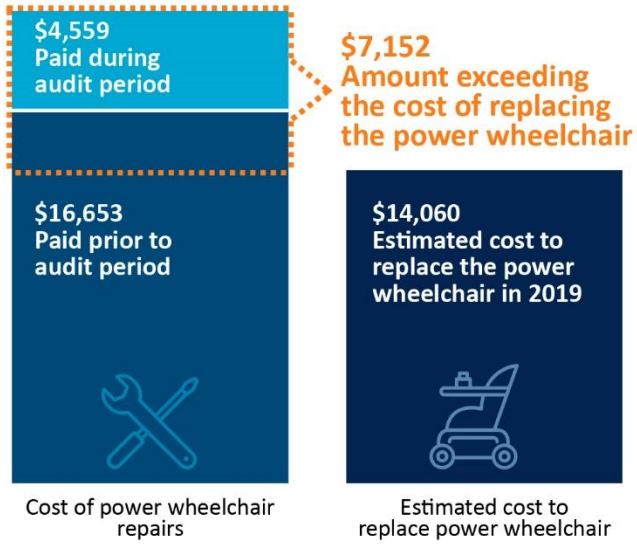
See the following page for an example of a supplier that submitted charges for repairs made to a sampled beneficiary's power wheelchair during the 5-year RUL after the total accumulated cost of repairing the power wheelchair had exceeded the replacement cost.

[43] To be conservative, we considered 100 percent of the cost of replacing the power wheelchairs rather than the 60 percent suggested by Federal regulations. Although the total cost of repairs for these eight power wheelchairs exceeded the purchase price by $18,606, the amount in excess of the purchase price that was paid during our audit period was $13,934.

Example of Accumulated Costs of Power Wheelchair Repairs Provided During the 5-Year Reasonable Useful Lifetime That Exceeded 100 Percent of the Replacement Cost

One supplier submitted charges for 14 PMD repairs made to a sampled beneficiary's power wheelchair and received $4,559 in Medicare payments. (Eight repairs were made on one date of service, and six repairs were made on another date of service.) When the last repair was made, the sampled beneficiary had owned the power wheelchair for approximately 4 years and 3 months. Before our audit period, Medicare had paid $16,653 for repairs made to this beneficiary's wheelchair even though the estimated cost to replace the wheelchair would have been $14,060. In total, Medicare paid $21,212 for PMD repairs made within the power wheelchair's 5-year RUL. This amount exceeded the cost of replacing the power wheelchair by $7,152 (51 percent). The $4,559 paid to the supplier for the PMD repairs in our sample may not have been reasonable and necessary. (See Figure 2.)

Figure 2: PMD Repair Costs vs. the Estimated Cost To Replace a Sampled Beneficiary's Wheelchair



Suppliers Submitted Charges for Replacing Power Mobility Device Parts That Had Been Replaced Within the Previous 12 Months

For seven PMD repairs associated with three sampled beneficiaries, suppliers submitted charges for replacing PMD parts that had been replaced within the previous 12 months from the sampled dates of service. These suppliers did not have warranties to cover the PMD repairs made; instead, they submitted charges to Medicare for the same PMD repairs that had been made within the previous 12 months.

For example, one supplier submitted charges for PMD repairs that included replacing the swing-away joystick mount on a sampled beneficiary's power wheelchair on August 26, 2019, and received $161 in Medicare payments. This supplier had previously received $161 in Medicare payments for the same PMD repair provided on April 25, 2019. The supplier's documentation supported that this item was repaired on both dates of service. When we requested warranty documentation, the supplier stated that the PMD was under a 1-year manufacturer warranty from the date of purchase on December 29, 2016, and the warranty had expired. In addition, the supplier stated that there was no supplier warranty for PMD repairs. The $161 paid to the supplier for the same PMD repair that had been made 4 months earlier may not have been reasonable and necessary. The charges might have been prevented if Medicare had required warranties for repairs.

CMS Did Not Have Adequate Medicare Requirements To Prevent Suppliers From Submitting Questionable Power Mobility Device Repair Charges

The payments for questionable PMD repair charges occurred because CMS did not have adequate Medicare requirements to prevent suppliers from submitting PMD repair charges that did not meet documentation standards established by guidance or that may not have been reasonable and necessary. Specifically, Medicare requirements did not specify that:

- suppliers must have timely documentation to support that the PMDs being repaired continued to be reasonable and necessary,[44]

- the accumulated costs of repairs made to a power wheelchair during its 5-year RUL must not exceed a certain threshold,[45] and

- suppliers must provide warranties for repairs made to PMDs.[46]

SUPPLIERS RECEIVED IMPROPER AND QUESTIONABLE PAYMENTS FOR POWER MOBILITY DEVICE REPAIRS

Suppliers received improper Medicare payments of $41,137 for 261 repairs made to PMDs that belonged to 76 beneficiaries in our sample. In addition, these beneficiaries paid $10,494 in coinsurance. On the basis of our sample results, we estimated that $7.9 million of the

[44] Documentation is considered timely when it is on record in the 12 preceding months from the PMD repair date of service.

[45] Medicare requirements suggest but do not require that the DME MACs consider whether the accumulated costs of repairs exceed 60 percent of the cost to replace the power wheelchair.

[46] Medicare requirements state that PMD parts covered by warranties are not eligible for Medicare reimbursement but do not require that warranties be provided for PMD repairs.

$40.1 million was improperly paid to suppliers for PMD repairs. We also estimated that Medicare beneficiaries paid $2 million in coinsurance for these PMD repairs.[47]

Suppliers received an additional $20,692 in questionable payments for 183 PMD repairs associated with 19 sampled beneficiaries. In addition, these beneficiaries paid $5,278 in coinsurance for the associated PMD repairs. For these repairs, suppliers did not meet the documentation standards established by guidance or submitted PMD repair charges that may not have been reasonable and necessary. On the basis of our sample results, we estimated that Medicare could have saved as much as an additional $3.7 million for these PMD repairs and beneficiaries could have saved as much as $1 million in coinsurance if CMS had had adequate Medicare requirements to prevent payments for questionable PMD repair charges.[48]

CONCLUSION

Adequate oversight helps to ensure that suppliers comply with Medicare requirements and that Medicare pays only for PMD repair charges that are reasonable and necessary.

During our audit period, the DME MACs had oversight mechanisms, such as system edits, to identify for review PMD repairs billed using certain HCPCS codes. However, because these edits did not apply to all PMD repairs, the DME MACs did not always identify PMD repair charges that may have been excessive or that may have exceeded the estimated cost to replace the PMDs being repaired. In addition, when the DME MACs reviewed PMD repairs, they did not review supplier documentation, which is the main source used to determine whether suppliers complied with Medicare requirements and whether the submitted charges were allowable for reimbursement. Without reviewing supporting documentation, the DME MACs could not verify that PMD repairs were adequately documented and that the repair charges were reasonable and necessary.

Why Is Documentation Important?

Proper documentation is important to protect the Medicare program and its beneficiaries. Accurate documentation helps ensure that Federal health care programs pay the right amount to the right people and that beneficiaries receive items or services that are reasonable and necessary.

Furthermore, CMS and DME MACs established Medicare guidance to educate suppliers and to assist in implementing requirements for PMD repairs. However, CMS did not have adequate Medicare requirements to prevent payments for questionable PMD repair charges. Specifically, the Medicare requirements did not: (1) include the documentation

[47] The estimated coinsurance amount was $2,027,592.

[48] The estimated coinsurance amount was $953,933.

standards established by guidance for PMD repairs, (2) specify that accumulated costs of repairs made to power wheelchairs during their 5-year RUL must not exceed a certain threshold, and (3) specify that suppliers must provide warranties for repairs made to PMDs.

Additional steps are necessary to help reduce payments for improper and questionable PMD repair charges and to protect beneficiaries from paying unnecessary coinsurance related to excessive PMD repair charges. CMS could have saved Medicare an estimated $11.6 million and its beneficiaries could have saved as much as $3 million if CMS had taken the necessary steps to implement proper oversight mechanisms, including requiring the DME MACs to implement a system edit that identifies PMD repairs for review of supplier documentation and establishing adequate Medicare requirements for PMD repairs.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services instruct the DME MACs to:

- recover $41,137 in overpayments for PMD repairs made to PMDs that belonged to 76 sampled beneficiaries;

- notify the suppliers to refund $10,494 in coinsurance that was collected from the 76 sampled beneficiaries;

- based upon the results of this audit, notify appropriate suppliers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the suppliers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and

- improve the education of suppliers on Medicare requirements for PMD repairs and for documenting labor time spent on repairs.

We also recommend that the Centers for Medicare & Medicaid Services work with the DME MACs to do the following, which could have saved Medicare an estimated $7,948,182 during our audit period:

- Implement a system edit that applies to all PMD repairs and identifies PMD repairs for review of supplier documentation to help ensure that PMD repairs are adequately documented and that the PMD repair charges are reasonable and necessary.

- Implement a system edit to determine whether PMD repair charges exceed the estimated cost to replace the PMDs being repaired.

In addition, we recommend that the Centers for Medicare & Medicaid Services establish Medicare requirements that: (1) include the documentation standards established by guidance for PMD repairs; (2) specify that accumulated costs of repairs made to power wheelchairs during their 5-year RUL must not exceed a certain threshold; and (3) specify that suppliers must provide warranties for repairs made to PMDs, which could have saved Medicare an estimated $3,739,346 during our audit period.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first, second, third, fourth, and sixth recommendations. For these five recommendations, CMS stated that: (1) it will instruct its DME MACs to recover the identified overpayments consistent with relevant law and CMS's policies and procedures; (2) as a part of the overpayment recovery process, the DME MACs will notify the suppliers so that they may refund any deductible or coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf; (3) it will instruct its DME MACs to notify identified suppliers of potential overpayments and track any returned overpayments made in accordance with this recommendation and the 60-day rule; (4) it will work with the DME MACs to continue to educate suppliers regarding proper billing and Medicare requirements for PMD repairs; and (5) it will evaluate the feasibility of a system edit to determine whether PMD repair charges exceed the estimated cost to replace the PMDs, and it will notify the DME MACs so that they may evaluate the risk associated with these claims as part of their annual Improper Payment Reduction Strategy.

However, CMS did not concur with our fifth recommendation. In addition, CMS did not explicitly state its concurrence or nonconcurrence with the first two parts of our seventh recommendation and did not concur with the third part of that recommendation, which relates to CMS establishing Medicare requirements to specify that suppliers must provide warranties for repairs made to PMDs. Our summaries of CMS's comments on the fifth and seven recommendations and our responses are in the sections below. After reviewing CMS's comments, we maintain that our recommendations are valid.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix E.

FIFTH RECOMMENDATION: IMPLEMENTING A SYSTEM EDIT THAT APPLIES TO ALL POWER MOBILITY DEVICE REPAIRS

CMS Comments

CMS did not concur with our fifth recommendation and stated that a system edit that applies to all PMD repairs for the purpose of manual review would be resource-intensive. CMS stated that it will notify the DME MACs of our audit so that they may evaluate the risk associated with PMD repair claims as part of their annual Improper Payment Reduction Strategy.

Office of Inspector General Response

We continue to recommend that CMS work with the DME MACs to implement a system edit that applies to all PMD repairs. For example, CMS and the DME MACs could implement an edit that applies to all PMD repairs and identifies for review certain PMD repair claims that the DME MACs deem appropriate for review. The DME MACs would need to review supporting documentation only for the selected claims identified for review, which would be less resource-intensive than reviewing every PMD repair claim. Without such edits and reviews, the DME MACs may not be able to adequately identify the risks associated with PMD repair claims. Currently, the DME MACs manually review PMD repair claims data that include HCPCS codes for miscellaneous PMD parts and HCPCS codes that require a narrative statement, and do not request or review supporting documentation.

SEVENTH RECOMMENDATION: ESTABLISHING MEDICARE REQUIREMENTS

CMS Comments

CMS did not explicitly state its concurrence or nonconcurrence with the first two parts of our seventh recommendation, which states that CMS establish Medicare requirements that include the documentation standards established by CMS and DME MAC guidance for PMD repairs and specify that accumulated costs of repairs made to power wheelchairs during their 5-year RUL must not exceed a certain threshold. In addition, CMS did not concur with the third part of that recommendation, which states that CMS establish Medicare requirements specifying that suppliers must provide warranties for repairs made to PMDs. CMS stated that it did not believe our recommended requirements for PMD repairs would be considered coverage requirements but may be considered as general payment rules or conditions of payment.

CMS provided the following comments:

- CMS stated that in 2019, after our audit period, it underwent notice-and-comment rulemaking to streamline requirements for ordering DME items and that the purpose of the final rule was to "simplify and revise conditions of payment aimed at reducing unnecessary utilization and aberrant billing" for these items. CMS stated that it must always be mindful of balancing program integrity concerns with the regulatory burden and that additional regulation and documentation requirements may cause undue burden on suppliers. CMS noted that changes to the documentation standards as a condition of payment would require notice-and-comment rulemaking.

- CMS stated that it previously underwent notice-and-comment rulemaking proposing that the supplier must replace beneficiary-owned capped rental items at no cost to the beneficiary or to the Medicare program if the total accumulated costs of repairs exceed 60 percent of the replacement cost and the item has been in continuous use for less than its RUL. CMS stated that the final rule was revised to reflect a more general policy

based on comments received stating that the proposed threshold may not have been pertinent in all cases.

- CMS stated that it believed its actions in response to our "other recommendations to strengthen the payment rule related to supplier replacement of beneficiary-owned equipment based on accumulated repaid costs and limit payments for unnecessary repairs" would subsequently address our concerns regarding supplier warranties. CMS stated that, therefore, it did not concur with our recommendation to require suppliers to provide warranties for repairs made to PMDs.[49]

Office of Inspector General Response

We continue to recommend that CMS establish Medicare requirements that: (1) include the documentation standards established by guidance for PMD repairs, (2) specify that accumulated costs of repairs made to power wheelchairs during their 5-year RUL must not exceed a certain threshold, and (3) specify that suppliers must provide warranties for repairs made to PMDs.[50]

The following are our responses to CMS's specific comments:

- We do not agree that additional documentation requirements would cause undue burden to suppliers, because the DME MACs' guidance currently states that suppliers must meet these standards.[51] In addition, we understand that CMS must allow for notice-and-comment rulemaking when proposing Medicare requirements, and we encourage CMS to do so. Notably, these documentation standards previously underwent the notice-and-comment rulemaking process and were included in PMD-related LCDs, which are considered Medicare requirements. The DME MACs removed these documentation standards from the LCDs effective January 1, 2017, and

[49] In separate correspondence with us, CMS clarified that it believed all actions that strengthen the existing payment rules related to repairs (i.e., recouping identified overpayments, notifying appropriate suppliers of the 60-day rule, providing additional education to suppliers, and evaluating the feasibility of a system edit to determine whether PMD repairs exceed the estimated cost to replace the PMD) would remove any need for the consideration of supplier warranties.

[50] In our draft report, our seventh recommendation referred to CMS establishing Medicare coverage requirements. Based on CMS's comments, we revised the recommendation to remove the word "coverage."

[51] The LCA that includes these documentation standards states that documentation requirements are compiled from statutes, the Code of Federal Regulations, CMS manuals, and DME MAC publications (LCA A55426). This LCA sets out the general standards that are applicable to all DME claims submitted to the DME MACs. The PMD-related LCDs state that suppliers must meet the documentation standards included in the LCA before Medicare reimbursement.

moved these standards into one LCA to lessen the administrative burden of maintaining the documentation standards in individual LCDs.[52]

- We understand that the final rule was revised to reflect a more general policy regarding the accumulated costs of repairs made to power wheelchairs within their 5-year RUL. Therefore, the Medicare requirements did not specify that accumulated costs of repairs made to power wheelchairs during their 5-year RUL must not exceed a specific threshold. Instead, the requirements indicated that the DME MACs *may* consider whether the accumulated costs of repairs exceed 60 percent of the cost to replace the power wheelchair when determining that the power wheelchair will not last for the entire 5-year RUL. During the notice-and-comment rulemaking process, CMS stated that even though it agreed to remove the 60 percent threshold as part of the final rule, it continued to believe that this threshold was a useful factor for DME MACs to consider because "it is probative of whether the beneficiary has been furnished with, and Medicare has paid for, a substandard item." In addition, CMS informed us that this regulation provides discretion for the DME MACs to apply the threshold in situations where their review shows it is applicable. However, because CMS did not require the DME MACs to use a specific threshold to review accumulated costs of repairs made to power wheelchairs during their 5-year RUL, the DME MACs have not reviewed for accumulated costs of PMD repairs. Unless specific requirements are established, suppliers will continue to receive Medicare payments (and the associated beneficiary coinsurance) for excessive PMD repairs throughout the power wheelchairs' 5-year RUL, without oversight mechanisms in place to prevent questionable payments.

- It is unclear how CMS's actions in response to any of our recommendations would address our concerns regarding supplier warranties. Therefore, we continue to recommend that CMS establish Medicare requirements that specify that suppliers must provide warranties for repairs made to PMDs so that suppliers cannot repeatedly bill for repairs that had already been paid by Medicare within the same year.

[52] One DME MAC stated that the decision to move the documentation standards from the individual LCDs to one LCA was due to the DME MACs' administrative burden of maintaining documentation standards in each LCD. Changes to general documentation standards would require updating over 50 individual LCDs and LCD-related Policy Articles, increasing the risk of clerical errors.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part B paid claims for 37,013 beneficiaries for whom suppliers submitted charges for 244,667 claim lines, totaling $40,107,042, for PMD repairs provided from October 1, 2018, through September 30, 2019. The beneficiary coinsurance associated with these PMD repairs totaled $10,359,717. A claim line represented one PMD repair for a beneficiary on a single date of service. We grouped the claim lines by beneficiary and included in the sampling frame beneficiaries associated with PMD repairs that totaled $150 or more. We selected a stratified random sample of 100 beneficiaries, for whom 52 suppliers submitted charges for 922 repairs totaling $170,776.

Suppliers provided us with supporting documentation for the sampled beneficiaries. Many suppliers also provided medical records to support the PMD repairs in our sample. However, for some sampled beneficiaries, suppliers were unable to provide medical records. In those cases, we requested the medical records directly from the treating physicians. We reviewed the documentation to determine whether suppliers complied with Medicare requirements when billing for PMD repairs; however, we did not determine whether the PMDs were medically necessary.

We did not perform an overall assessment of the internal control structures of CMS or the DME MACs. Rather, we limited our review to those controls that were significant to our objective. Specifically, our review of internal controls focused on the control activities for processing and reviewing Medicare claims for PMD repairs. We assessed whether CMS and the DME MACs designed their information systems (i.e., system edits) and control activities to achieve objectives and respond to risks. We also assessed whether CMS implemented control activities through its policies.

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit from January 2020 to February 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- interviewed CMS and DME MAC officials to obtain an understanding of Medicare requirements and guidance for PMD repairs;

- obtained from CMS's NCH file the Medicare Part B paid claim lines for PMD repairs that suppliers provided during our audit period;

- created a sampling frame of 37,013 beneficiaries that received PMD repairs from suppliers nationwide during our audit period by consolidating 244,667 claim lines for PMD repairs by beneficiary, and selected a stratified random sample of 100 beneficiaries (Appendix C);

- reviewed data from CMS's Common Working File and other available data for the sampled beneficiaries' claim lines to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file and to determine whether claim lines had been canceled or adjusted;

- obtained documentation from suppliers and physicians as support for the repairs made to the PMDs that belonged to the sampled beneficiaries and determined whether suppliers complied with Medicare requirements and guidance for each of the PMD repairs billed;

- reviewed the Medicare Physician Fee Schedule to determine the cost of replacing the PMDs (and related accessories) in our sample and compared that with the cost of the repairs in our sample to determine whether suppliers billed for repairs that exceeded the cost of replacing the PMDs;

- analyzed claims data for each sampled beneficiary to determine whether the PMD being repaired was within its 5-year RUL during our audit period;

- analyzed the claims data for PMD repairs for each sampled beneficiary that had a power wheelchair within its 5-year RUL to determine whether the accumulated cost of the repairs provided during the 5-year RUL exceeded the cost of replacing the power wheelchair;

- categorized our audit findings into those that were and were not based on Medicare requirements;

- estimated the payments for improper and questionable PMD repair charges billed by suppliers and the beneficiary coinsurance associated with these repairs (Appendix D); and

- discussed the results of our audit with CMS officials.

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

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR OF GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Could Save Millions by Eliminating the Lump-Sum Purchase Option for All Power Mobility Devices	A-05-15-00020	5/17/2017
Hoveround Corporation Claimed Millions in Federal Reimbursement for Power Mobility Devices That Did Not Meet Medicare Requirements	A-05-12-00057	12/3/2015
Medicare Paid Suppliers for Power Mobility Device Claims That Did Not Meet Federal Requirements for Physicians' Face-to-Face Examinations of Beneficiaries	A-09-12-02068	1/16/2015
Review of Power Mobility Devices Supplied by Marquis Mobility, Inc.	A-05-10-00042	5/3/2012
Most Power Wheelchairs in the Medicare Program Did Not Meet Medical Necessity Guidelines	OEI-04-09-00260	7/7/2011
Review of Medicare Payments to D and M Sales, LLC, for Power Mobility Devices for Calendar Years 2006–2008	A-09-10-02005	9/15/2010
A Review of Claims for Capped Rental Durable Medical Equipment	OEI-07-08-00550	August 2010
Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements	OEI-04-07-00401	December 2009
Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services	OEI-04-07-00400	August 2009
Miscoded Claims for Power Wheelchairs in the Medicare Program	OEI-04-07-00403	7/13/2009
A Comparison of Medicare Program and Consumer Internet Prices for Power Wheelchairs	OEI-04-07-00160	October 2007

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame contained 37,013 beneficiaries consisting of 244,667 Medicare Part B claim lines for PMD repairs provided during our audit period for which suppliers nationwide were paid a total of $40,107,042.[53] We included in the sampling frame beneficiaries associated with PMD repair payment amounts of $150 or more and that were not associated with a previous CMS contractor's review. The beneficiary coinsurance associated with these PMD repairs totaled $10,359,717.

SAMPLE UNIT

The sample unit was a beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. To accomplish this, we separated the sampling frame into three strata (Table 1).

Table 1: Strata in Sampling Frame

Stratum	Description	Number of Beneficiaries	Medicare Payment Frame Dollar Value	Coinsurance Dollar Value Related to the Frame	Sample Size
1	Beneficiaries with total PMD repair charges that were equal to or greater than $150 but less than $1,500	28,464	$17,779,890	$4,658,952	50
2	Beneficiaries with total PMD repair charges that were equal to or greater than $1,500 but less than $2,750	6,043	12,159,171	3,102,707	25
3	Beneficiaries with total PMD repair charges that were equal to or greater than $2,750	2,506	10,167,981	2,598,058	25
Total		**37,013**	**$40,107,042**	**$10,359,717**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

[53] A claim line represented one PMD repair for a beneficiary on a single date of service.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sampling frame by the health insurance claim number and then consecutively numbered the beneficiaries in each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate: (1) the amount overpaid by Medicare for PMD repair charges that did not comply with Medicare requirements and the associated coinsurance amount and (2) the amount Medicare could have saved for questionable PMD repair charges and the associated coinsurance amount. (See Appendix D for our estimates.)

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Detail

Stratum	Number of Beneficiaries in Frame	Value of Medicare Payment in Frame	Value of Coinsurance Related to Frame	Size of Sample	Value of Medicare Payment in Sample	Value of Coinsurance Related to Sample	Number of PMD Repairs in Sample
1	28,464	$17,779,890	$4,658,952	50	$30,700	$7,832	253
2	6,043	12,159,171	3,102,707	25	51,092	13,034	272
3	2,506	10,167,981	2,598,058	25	88,984	22,700	397
Total	**37,013**	**$40,107,042**	**$10,359,717**	**100**	**$170,776**	**$43,566**	**922**

Table 3: Sample Results for Improperly Paid PMD Repairs

Stratum	Number of Improperly Paid PMD Repairs in Sample	Value of Medicare Payment for Improperly Paid PMD Repairs in Sample	Value of Coinsurance Related to Improperly Paid PMD Repairs in Sample
1	59	$5,008	$1,278
2	72	10,428	2,660
3	130	25,701	6,556
Total	**261**	**$41,137**	**$10,494**

Table 4: Sample Results for Questionably Paid PMD Repairs

Stratum	Number of Questionably Paid PMD Repairs in Sample	Value of Medicare Payment for Questionably Paid PMD Repairs in Sample	Value of Coinsurance Related to Questionably Paid PMD Repairs in Sample
1	20	$1,256	$320
2	80	7,606	1,940
3	83	11,830	3,018
Total	**183**	**$20,692**	**$5,278**

Table 5: Estimated Values of Improperly Paid PMD Repairs and Associated Coinsurance in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

	Medicare Payment for Improperly Paid PMD Repairs	Coinsurance
Point estimate	$7,948,182	$2,027,592
Lower limit	6,400,617	1,632,805
Upper limit	9,495,746	2,422,378

Table 6: Estimated Values of Questionably Paid PMD Repairs and Associated Coinsurance in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

	Medicare Payment for Questionably Paid PMD Repairs	Coinsurance
Point estimate	$3,739,346	$953,933
Lower limit	2,259,147	576,322
Upper limit	5,219,545	1,331,543

APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: March 31, 2022

TO: Amy J. Frontz
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Durable Medical Equipment Suppliers an Estimated $8 Million of the $40 Million Paid for Power Mobility Device Repairs (A-09-20-03016)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers and suppliers on proper billing. CMS educates health care providers and suppliers on Medicare billing through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. For example, in June 2021 CMS published a MLN booklet for power mobility devices, which includes details on coverage criteria and practitioner requirements.[1] CMS maintains a webpage outlining Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) order requirements.[2] The Durable Medical Equipment Medicare Administrative Contractors have also provided education on DMEPOS and power mobility device replacement and repairs.[3]

The OIG's recommendations and CMS' responses are below.

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/pmd_DocCvg_FactSheet_ICN905063.pdf
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/FacetoFaceEncounterRequirementforCertainDurableMedicalEquipment
[3] https://cgsmedicare.com/jc/help/faqs/current/COPE14779.html; https://med.noridianmedicare.com/web/jddme/topics/repairs/repairs

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services instruct the DME MACs to recover $41,137 in overpayments for PMD repairs made to PMDs that belonged to 76 sampled beneficiaries.

CMS Response
CMS concurs with this recommendation. CMS will instruct its Durable Medical Equipment Medicare Administrative Contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services instruct the DME MACs to notify the suppliers to refund $10,494 in coinsurance that was collected from the 76 sampled beneficiaries.

CMS Response
CMS concurs with this recommendation. As part of the overpayment recovery process, the Durable Medical Equipment Medicare Administrative Contractors will notify the suppliers so that they may refund any deductible or coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services instruct the DME MACs to based upon the results of this audit, notify appropriate suppliers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the suppliers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

CMS Response
CMS concurs with this recommendation. CMS will analyze OIG's data to identify appropriate suppliers to notify of potential overpayments. CMS will then instruct its Durable Medical Equipment Medicare Administrative Contractors to notify the identified suppliers of OIG's audit and the potential overpayment and track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services instruct the DME MACs to improve the education of suppliers on Medicare coverage requirements for PMD repairs and for documenting labor time spent on repairs.

CMS Response
CMS concurs with this recommendation. CMS will work with the Durable Medical Equipment Medicare Administrative Contractors to continue to educate suppliers regarding proper billing and Medicare requirements for DMEPOS repairs, which includes power mobility device repairs.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services work with the DME MACs to implement a system edit that applies to all PMD repairs and identifies PMD repairs for

review of supplier documentation to help ensure that PMD repairs are adequately documented and that the PMD repair charges are reasonable and necessary.

CMS Response

CMS does not concur with this recommendation. A system edit that applies to all power mobility device repairs for the purpose of manual review would be resource intensive. CMS will notify the Durable Medical Equipment Medicare Administrative Contractor of the OIG's audit so that they may evaluate the risk associated with these claims as part of their annual Improper Payment Reduction Strategy.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services work with the DME MACs to implement a system edit to determine whether PMD repair charges exceed the estimated cost to replace the PMDs being repaired.

CMS Response

CMS concurs with this recommendation. CMS will evaluate the feasibility of a system edit to determine whether power mobility device repair charges exceed the estimated cost to replace the PMDs. CMS will notify the Durable Medical Equipment Medicare Administrative Contractor of the OIG's audit so that they may evaluate the risk associated with these claims as part of their annual Improper Payment Reduction Strategy.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services establish Medicare coverage requirements that: (1) include the documentation standards established by guidance for PMD repairs, (2) specify that accumulated costs of repairs made to PMDs during their 5-year RUL must not exceed a certain threshold, and (3) specify that suppliers must provide warranties for repairs made to PMDs.

CMS Response

The Social Security Act is the primary authority for all coverage provisions and subsequent policies. Generally, Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member, and within the scope of a Medicare benefit category. In certain cases, CMS deems it appropriate to develop a National Coverage Determination (NCD) for an item or service to be applied on a national basis for all Medicare beneficiaries meeting the criteria for coverage. Medicare Administrative Contractors may also develop Local Coverage Determinations (LCDs) when there is no NCD or when there is a need for additional guidance that is consistent with an NCD in a geographical area.

CMS does not believe that the recommended requirements for power mobility device repairs outlined above would be considered coverage requirements. However, these recommendations may be considered as general payment rules or conditions of payment. See below:

(1) In 2019, after the OIG's audit period, CMS underwent notice and comment rulemaking to streamline requirements for ordering DMEPOS items (Final Rule CMS 1713).[4] The purpose of the rule was to simplify and revise conditions of payment aimed at reducing unnecessary utilization and aberrant billing for DMEPOS items. CMS must always be mindful of balancing program integrity concerns with the regulatory burden. Additional

[4] https://www.govinfo.gov/content/pkg/FR-2019-11-08/pdf/2019-24063.pdf

regulation and documentation requirements may cause undue burden on providers and suppliers. Changes to the documentation standards as a condition of payment would require notice and comment rulemaking.

(2) CMS previously underwent notice and comment rulemaking proposing that the supplier must still replace beneficiary owned capped rental items at no cost to the beneficiary or to the Medicare program if the total accumulated costs to repair an item after the transfer of title to the beneficiary exceed 60 percent of the replacement cost and the item has been in continuous use for less than its reasonable useful lifetime. The final rule was revised to reflect a more general policy based on comments received stating that the proposed 60 percent threshold may not be pertinent in all cases.[5]

(3) Based on the findings of this report, CMS believes the actions in response to the other recommendations to strengthen the payment rule related to supplier replacement of beneficiary-owned equipment based on accumulated repaid costs and limit payments for unnecessary repairs will subsequently address OIG's concerns regarding supplier warranties. Therefore, CMS does not concur with the recommendation to require suppliers to provide warranties for repairs made to PMDs

[5] https://www.govinfo.gov/content/pkg/FR-2006-11-09/pdf/06-9068.pdf