# TESTIMONY OF
# HERB KUHN
# DIRECTOR, CENTER FOR MEDICARE MANAGEMENT
# CENTERS FOR MEDICARE & MEDICAID SERVICES
# ON
# POWER OPERATED WHEELCHAIRS
# BEFORE THE
# SENATE FINANCE COMMITTEE

**APRIL 28, 2004**

Chairman Grassley, Senator Baucus, thank you for inviting me to discuss Medicare's coverage and payment policies regarding motorized wheelchairs and power operated vehicles (POV)/scooters. I want to thank you for your leadership in making sure that fraud, waste, and abuse are addressed in Centers for Medicare & Medicaid Services' (CMS') programs. As you know, working together using the additional authorities you have given us, we have reduced fraud significantly across the Medicare program. For example, since 1996 when CMS first began measuring Medicare's payment error rate, the rate has decreased by more than half from 13.8 percent to 5.8 percent. While we have made much progress, we must remain vigilant to ensure that Medicare's beneficiaries continue to receive the care and coverage they need and that we fulfill our fiduciary responsibilities to the American taxpayer. The wheelchair benefit is one such area where the Agency has worked to develop a comprehensive program to effectively manage spending while not affecting access to this very important service. Achieving these two goals requires CMS to remain vigilant both on behalf of the beneficiary and on behalf of the taxpayer, a challenge in the best of circumstances.

Over the years technical progress in power mobility devices has led to more options that provide better assistance to beneficiaries with disabilities. At the same time this growth in options has resulted in significant increases in prices and thus, growth in expenditures. CMS has undertaken a number of initiatives in response to the problems that were identified with significant growth in expenditures for motorized wheelchairs. Although these initiatives have helped, CMS has determined there was and continues to be a need for more comprehensive actions to fully stem the tide of abuse and ensure that beneficiaries who truly need these items have access to them. Building on our past

efforts and last fall's Operation Wheeler Dealer (OWD), we are now undertaking a broad three-pronged initiative to address coverage, payment, and quality of motorized wheelchair suppliers. With input from key stakeholders, CMS will provide guidance on implementing coverage policy to ensure appropriate coverage of power wheelchairs through a consensus-driven, evidence-based process. In addition, to better serve our current and future beneficiaries, we will ensure that payment is appropriate through mandated fee schedule adjustments, coding updates, and competitive bidding. Furthermore, CMS will ensure that beneficiaries get high-quality mobility services by revising supplier standards, implementing an accreditation process, and continuing to scrutinize applications from potential suppliers to make sure they are qualified.

Mr. Chairman, although we have faced many challenges, I assure you our efforts to obtain high value and prevent fraud will continue and be augmented further by these additional bold steps to protect the Medicare Trust Fund while ensuring beneficiary access. I would like to describe for you the challenge before this Agency, the past and current initiatives to address it, and our plan of action for the future.

## The Challenge

Medicare covers power wheelchairs under limited circumstances and, as the quality of mobility devices continues to improve, it is more important than ever that those beneficiaries who qualify for coverage continue to have access to the devices. At the same time, due to the high payment rate for power wheelchairs (more than $5000 not including the cost of accessories under our payment rules), they present a lucrative opportunity for those who would defraud Medicare and its beneficiaries. Total allowed charges for power wheelchairs in 2003 will be approximately $1.2 billion when all remaining claims for items furnished in 2003 are received and processed up from $289 million in 1999. This is an increase of more than 300 percent over the past five years. This growth greatly outpaced all other economic indicators including growth in Medicare Part A of 17 percent, Part B of 54 percent, and overall Medicare program growth of 31 percent over this same period.

**Prior and Current Initiatives**

CMS uses a broad set of approaches to respond to the challenges of overuse, abuse, and fraud for any benefit in Medicare while preserving beneficiary access to needed services. Such tools were applied to combat fraud and abuse related to power operated wheelchairs. CMS has worked with the Durable Medical Equipment Regional Carriers (DMERCs) (who process wheelchair claims on behalf of CMS), providers, and law enforcement partners to accomplish our objectives. Following are highlights of a number of such initiatives.

*1998: CMS Issues Fraud Alert*

The unusual spending growth in the power wheelchair benefit did not begin in 1999. In fact, the power wheelchair benefit has grown faster than spending on other items every year since 1994. Based on reviews conducted by the DMERCs, CMS began to notice inappropriate and potentially fraudulent use of the power wheelchair benefit. In response, CMS issued a fraud alert in October 1998 to all the DMERCs and law enforcement officials to notify them of problems that were being detected in claims data. This fraud alert explained techniques that were being used to obtain inappropriate payments for power wheelchairs and scooters and provided guidance on how to detect potential fraud and abuse of the benefit.

*1998 - 1999: Inherent Reasonableness under BBA and BBRA Authority*

Inherent Reasonableness (IR) is the authority provided to CMS to correct unreasonable Medicare payment amounts for specific items and services under Part B, including Durable Medical Equipment (DME). CMS utilized the authority in the Balanced Budget Act of 1997 to develop and issue an interim final rule (IFR) invoking IR for several DME items. However, in 1999, before using this authority to address power wheelchairs, the Balanced Budget Reconciliation Act (BBRA) revoked use of IR until four conditions were met: (1) the General Accounting Office (GAO) released its report on the IFR and our actions to utilize this authority; (2) CMS issued a notice of final rulemaking responding to the GAO's report and comments received on the IFR; (3) CMS reevaluated

its criteria for identifying unreasonable payment amounts in the final rule; and (4) CMS took steps to ensure use of valid and reliable data to determine IR.

CMS issued a new IFR December 13, 2002, that addressed the additional BBRA requirements and accepted the GAO recommendations related to IR. CMS is in the process of developing the general methodology to collect data necessary for making IR adjustments. Using the IR authority, CMS can lower its payment amounts for items if it can determine that the current payment amounts are grossly excessive (i.e., at least 15 percent greater than the amount determined to be realistic and equitable using valid and reliable data). We are currently working to obtain pricing information and are developing guidelines to implement the IR authority so that this option can be considered when addressing Medicare payment for power wheelchairs.

*1998 - Present: DMERC Claims Reviews Increase and Are Stalled by Objections to Administrative Requirements*

In the late 1990s, the DMERCs began to intensify their scrutiny of claims for power wheelchairs. The DMERCs tried many different techniques to ensure that claims met CMS coverage requirements. For example, one region required physical therapy notes or evaluations for all claims. Others began beneficiary and provider surveys to ensure compliance. Unfortunately, the power wheelchair industry objected to the increased scrutiny due to excessive administrative requirements, thus stalling actions on an industry-wide basis. However, CMS was able to continue focused reviews on particular problem providers, and continued to do so.

*2001-2002: CMS Supports Law Enforcement Operation in Texas*

CMS has always worked closely with and actively supported law enforcement investigations nationwide. Based on the number of referrals from the DMERCs made regarding potential fraud, law enforcement officials focused their investigations on the Texas area. In fact, a comparison of the number of DMERC referrals in all of 1999 to those in just the first quarter in 2004 shows an increase of 54 percent nationally, 360 percent in Texas, and 500 percent in Harris County, Texas.

*2002-2004: CMS Targets Fraud in Harris County, Texas*

In Harris County, Texas, Medicare paid for more than 31,000 power wheelchairs in 2002, compared to just more than 3,000 power wheelchairs in 2001, an almost tenfold increase. Even with this significant increase, however, it is difficult to identify a pattern of abuse at the moment it is occurring due to lags among billing, claims submission, claims payment, and aggregation of data. Furthermore, Medicare's four DMERCs process over 10 million claims each year, which adds to the challenges. Despite these challenges, as soon as CMS became aware of the magnitude of the fraud, CMS took swift action to uncover and remedy the various types of fraud.

The targeted efforts in Harris County have resulted in significant success. In May 2003, the billed amount for the main power wheelchair code by suppliers located in Harris County was $59.8 million. By August 2003, this figure dropped to $33.3 million and to $4.9 million by December 2003. We estimate that these, and other efforts directed specifically at Harris County, have prevented $140 million in unwarranted payments. In addition, as shown in Figure 1, the percentage of claims submitted and allowed in Harris County compared to national claims has returned to 2000 levels from a high of approximately 23 percent of national claims submitted and 17 percent of claims allowed in 2003. In the first quarter of 2004, only about 4.5 percent of claims originated in Harris County and about 0.1 percent of the national claims were paid to Harris County.

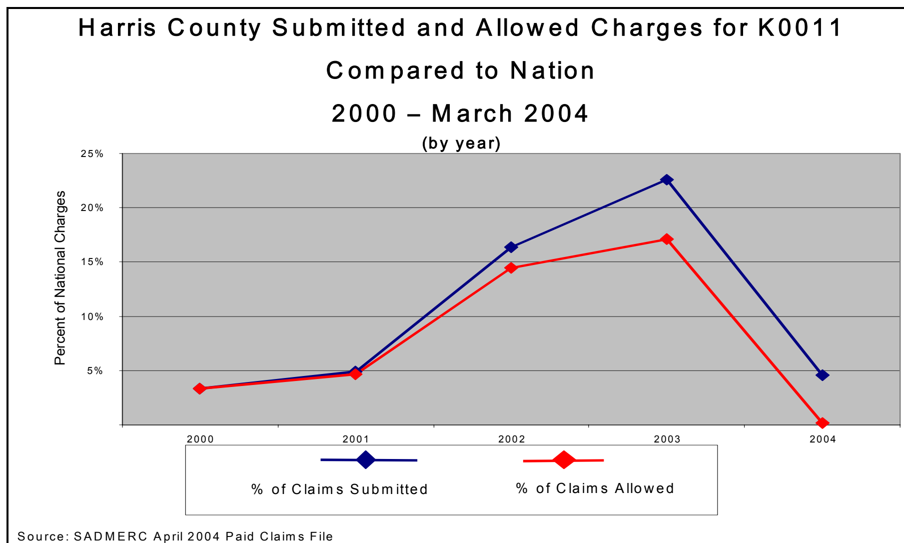


Figure 1

In addition, to prevent further fraud and abuse in Harris County, CMS' Dallas Regional Office ordered the Region C DMERC to take the unprecedented action of reviewing 100% of claims for power wheelchairs from Harris County. A special task force also was created in the Dallas office to individually approve all payments for motorized wheelchairs from Harris County. Furthermore, CMS required all power wheelchair suppliers in Harris County to attend mandatory training on wheelchair coverage and medical review policies. These initiatives continue today.

*2003: CMS Launches Operation Wheeler Dealer (OWD)*

CMS launched OWD to more carefully scrutinize wheelchair claims and to supress suppliers who appeared to be engaging in fraudulent or abusive marketing activities. In March 2003, CMS convened a task force to develop a more formal targeted course of action for the Agency at the national level. In September 2003, CMS launched OWD - a 10-point action plan designed to assure that the DMERCs were able to correctly process and pay claims. The response to the initiative has been positive. OWD has ensured access to wheelchairs for beneficiaries who needed them while substantially curbing abuse of the Medicare program by unscrupulous providers of power wheelchairs and other power mobility products. This plan addresses five main program areas that contributed to this growth in spending: fraud, supplier enrollment, application of Medicare coverage policy, payment, and education.

For example, CMS is aggressively reviewing applications from companies seeking to provide power wheelchairs to ensure they meet reputable business standards of operation. In the coming months, CMS will be creating new quality standards for suppliers to augment the current business standards to which all suppliers must adhere. These quality standards will further assure that CMS only enrolls suppliers who can be true long-term business partners. Using the existing coverage policy, the DMERCs targeted their reviews of claims by focusing on those services or providers that posed the greatest risk of loss to the program. The DMERCs will continue to deny payment for claims that do not meet CMS' coverage criteria. CMS and the DMERCs also are working together to

develop educational materials for physicians and beneficiaries that explain when power wheelchairs are appropriate. DMERCs also provide educational material to suppliers, including several articles explaining OWD and existing coverage policy. These actions are consistent with OIG recommendations.

*2004: OWD Results to Date*

In addition to the successes in Harris County, Texas, OWD has proven successful on a nationwide basis. Working collaboratively with the Department of Justice (DOJ) and the OIG, Federal officials have recovered $84 million in fraudulent claims for power mobility products nationwide since 2003. DMERCs have referred about 155 potential fraud cases (representing 265 suppliers) involving power wheelchairs to law enforcement since September 2003. About 10 percent of these cases have been closed already, indicating a very aggressive approach by law enforcement.

Law enforcement's expedience in addressing these cases demonstrates not only their commitment to working with CMS, but also the scope of the fraud that was occurring. For example, a doctor in Dallas recently pleaded guilty to health care fraud after defrauding Medicare out of almost $5.9 million for motorized wheelchairs. This particular doctor admitted to writing prescriptions for wheelchairs for beneficiaries who did not need them in exchange for kickbacks from suppliers.

In addition, DMERCs have opened an additional 77 investigations to determine whether these cases should be referred to law enforcement. An additional 196 cases are pending DMERC review.

Since the task force to develop OWD convened in March 2003, utilization and allowed charges for power wheelchairs declined from a monthly high of over $113 million in April, to about $69 million in December 2003, as shown in Figure 2. However, of the claims submitted, the number approved and paid rose from 60 percent to 80 percent, indicating that the accuracy and validity of claims have improved.

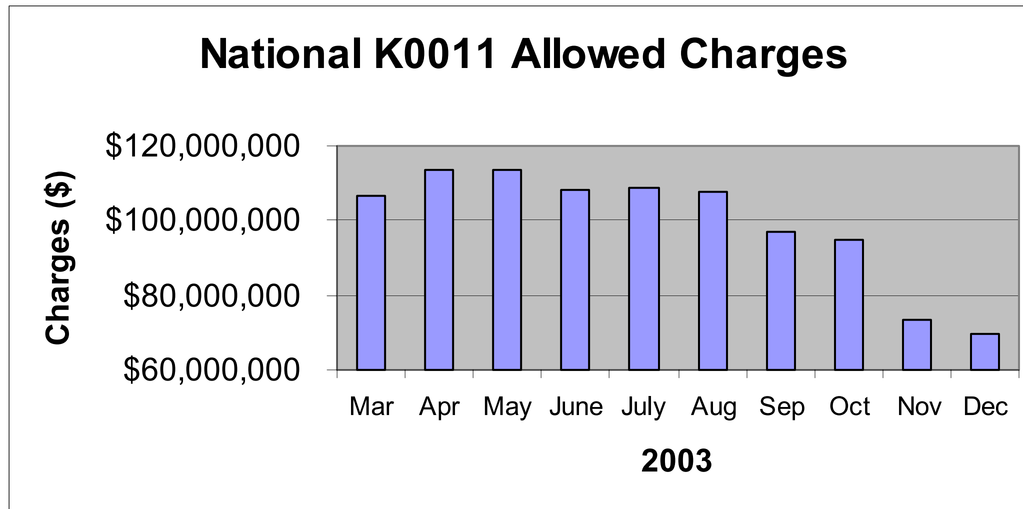


Figure 2

**Next Steps**

CMS plans to build on the success of OWD by implementing a three-pronged approach to address timely and appropriate coverage, payment, and quality of suppliers of power wheelchairs. These steps also encompass specific recommendations from the OIG regarding what CMS can do to address pricing and payment issues, specifically reviewing coding for power wheelchairs and educating providers and beneficiaries.

*Appropriate Coverage*

CMS is working on a proposed regulation to be issued later this year that will to address concerns related to power wheelchair coverage. The regulation will implement the provisions of theMedicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) with regard to power wheelchairs and scooters.

In addition to the regulation, CMS is examining steps to supplement our previous coverage guidance regarding "bed- or chair-confined" from a clinical and functional perspective. The goal is to focus on a set of clinical and functional characteristics that are evidenced-based and will better predict who would benefit from a power wheelchair or scooter. The Chief Medical Officer for CMS has already convened a group of clinicians

from across HHS and other agencies to describe the conditions that are associated with the current coverage definition and to develop guidance, including opportunities for public comment, for the DMERCs in making local coverage decisions. The group will start its work in May 2004 and intends to complete its work by year-end.

*Appropriate Payment*

Most power wheelchairs are billed using one Health Common Procedure Coding System (HCPCS) code for the base equipment (K0011) and additional codes for additional options or accessories. The technology, range of products, and market for power wheelchairs has changed substantially since the current HCPCS codes for power wheelchairs were added in late 1993. The fee schedule amounts for code K0011 are based on manufacturer suggested retail prices for 11 brands of wheelchairs made by 3 manufacturers in the early 1990s. Pricing information from OIG reports and other data gathered by CMS indicate that the current fee schedule ceiling for code K0011 of $5,296.50 is excessive and is an important contributing factor behind the startling growth in expenditures for this code. Our goal is to assure that Medicare pays appropriately for motorized wheelchairs, and ultimately, to have Medicare payments reflect market driven prices in a competitive bidding environment. We are pursuing this goal in three phases.

First, we are implementing the authority provided by Congress under the MMA to freeze the DME fee schedule amounts at 2003 levels for 5 years (2004 through 2008). This freeze was implemented through program instructions issued effective January 2004. Effective January 1, 2005, the MMA also requires CMS to reduce the fee schedule ceiling for base wheelchair equipment (K0011) by 3.28 percent from $5,296.50 to $5,122.74, a percentage reduction based on the difference between Medicare payments and the median payment made for these items under the Federal Employee Health Plans.

In addition to the changes under the MMA, CMS will work with a panel to make changes to the HCPCS coding for power wheelchairs that will establish a code set that better describes the power wheelchairs currently on the market and thus will assure that wheelchair payments are accurate. The industry and the OIG have recommended an

expansion in the HCPCS codes for power wheelchairs. The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is developing a preliminary recommendation for coding categories for the various combinations of power wheelchair bases and accessories. Once our proposal is developed and undergoes careful review by CMS policy and clinical staffs, we will consult with experts in other Federal agencies (such as the Veterans Administration), and solicit public comment. While it is not possible to predict with certainty the impact of these coding changes on price, we expect Medicare would pay less for basic power wheelchairs, less than or equal to what we pay for mid-level wheelchairs, and more for expensive products needed by specific patient populations. The net effect will likely be lower overall payments for wheelchairs, and more importantly, payments that are much more closely tied to the actual costs of these types of wheelchairs.

As required by MMA, CMS also is developing plans to implement its new authority to establish a competitive bidding process for DME. Competitive bidding will become a permanent part of Medicare with a phased-in process from 2007 through 2010. CMS intends to apply competitive bidding based on the revised mobility device codes just described.

The Secretary has the authority to designate which products to phase into competitive bidding based on the highest cost items, highest volumes, or items with the largest savings potential. Phase in of power wheelchairs will begin in 2007. Pursuant to the MMA, bidding will take place in at least 81 Metropolitan Statistical Areas (MSAs) across the country by 2010. Effective January 1, 2009, the payment information from competitive acquisition areas can be used to adjust the payment amounts for those items in other areas.

Full implementation of the competitive bidding program after 2009 will assure that the program is paying market-driven prices for power wheelchairs. In addition, more precise descriptions of the types of wheelchairs in the proposed new codes (described above) will lay the foundation for competitive bidding by establishing a code set that adequately

describes the range of power wheelchairs currently on the market. Furthermore, the contractor reform provisions under MMA will bring about performance-based contracting and other reforms that will enhance the quality and efficiency of contracts resulting from competitive bidding.

*Quality Standards*

Another goal of CMS is to ensure that there are appropriate quality controls for suppliers. We will revise the supplier standards for enrolling in Medicare to include quality measures as required by the MMA, building on existing standards in the industry. In the coming months, CMS will begin the steps to implement new supplier standards building on existing industry standards. CMS will also develop a proposal for an accreditation program, as part of the implementation of competitive bidding, to further ensure that power wheelchair suppliers meet industry and community standards for power wheelchair utilization. Lastly, CMS, through our contractor the National Supplier Clearinghouse, will continue its work to ensure thorough review of all applications for enrollment so that only qualified suppliers are allowed to bill the Medicare program.

**Conclusion**

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you again for inviting me to testify today about the issues involving Medicare's payment and coverage of motorized wheelchairs and scooters. While we remain vigilant in our efforts to eliminate fraud, we must keep in mind that many beneficiaries need and deserve this critical benefit and could be denied access. We have made substantial progress in identifying and eliminating fraudulent practices, while at the same time protecting beneficiary access to needed equipment. Taking steps to recover millions in fraudulent claims, CMS has outlined a broad reform agenda to further improve our systems. This agenda is consistent with the recommendations set forth by GAO and OIG.

Specifically the OIG recommended that CMS:

- Require DMERCs to address several areas within the coverage policy;
- Require DMERCs to conduct frequent reviews of the K0011 code;

- Create a new coding system to account for new models and prices; and
- Educate providers and beneficiaries about Medicare's coverage criteria.

As noted in the aforementioned testimony, CMS is already addressing several of these recommendations, for example:

- CMS is developing a regulation implementing MMA that would expand the categories of practitioners who can order POVs and would establish a requirement that the treating practitioner conduct a face-to-face examination for the beneficiary before writing a prescription for a POV.
- In addition, CMS will provide guidance on implementing coverage policy to ensure appropriate coverage of power wheelchairs through a consensus-driven evidence-based process.
- CMS also is examining changes to the HCPCS coding for power wheelchairs that will be developed based on recommendations by HHS and other Federal agencies' clinical experts along with input from the public.
- CMS currently is rolling out educational campaigns designed to provide physicians and beneficiaries with the necessary information about our coverage policies.

CMS' three-pronged initiative sets a very aggressive agenda and I believe this approach will improve access to high-quality power mobility devices for beneficiaries and ensure appropriate coverage through the regulatory process and guidance for DMERCs; will save money by providing appropriate payment for motorized wheelchairs through MMA, coding changes, and competitive bidding; and allow only qualified suppliers to bill the Medicare program through revised standards, accreditation, and thorough supplier application reviews.

Thank you again, and I look forward to answering any questions you might have.