

MOBILITY MATTERS

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MISLEADING OIG REPORT FAILS TO BLAME FLAWED CMS DOCUMENTATION PROCESS

WASHINGTON —The Inspector General’s Office (OIG) of the U.S. Department of Health and Human Services issued a report last week concluding that 61 percent of power wheelchairs provided to Medicare beneficiaries in the first half of 2007 “were medically unnecessary or had claims that lacked sufficient documentation to determine medical necessity.” But their report clearly indicated that medical necessity was actually only questioned on nine percent of the claims.

The OIG report reaffirmed that the major problem is not mobility equipment going to Medicare beneficiaries who don’t need it, but the government’s failure to establish a process that fairly and adequately documents a Medicare beneficiary’s medical necessity for a power wheelchair. In fact, the vast majority of claims cited by the OIG were flagged as improper because information was missing in the medical records of patients who received wheelchairs.

The fact that the OIG concluded that information was missing in 52 percent of the claims underscores that the government needs to fix the documentation process for determining the medical necessity for power wheelchairs. Despite the repeated pleadings of stakeholders — providers, physicians, clinicians, Medicare beneficiaries, consumer advocates and others — the Centers for Medicare and Medicaid Services (CMS) continues to utilize a flawed system that leaves physicians, providers and Medicare beneficiaries confused about what documentation is needed to satisfy their requirements.

Moreover, the flawed documentation system has become the basis for OIG reports and audits that unfairly create the perception that home medical equipment providers acted improperly and Medicare patients have received equipment that they don’t need. It’s unfortunate that these misconceptions are damaging the image of the Medicare program, providers and beneficiaries at a time when Congress is seeking spending cuts to address the nation’s escalating budget deficit.

“Stakeholders have asked CMS to improve the documentation process for years,” said Tyler Wilson, president of the American Association for Homecare (AAHomecare). “CMS must focus on establishing a process that works for the government, providers, physicians and Medicare beneficiaries. It should include a template that can assist the prescribing physicians in providing the extensive patient medical information that is being required. And CMS needs to adequately educate providers and physicians on what exactly is required, and how that information must be presented.”

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Let’s put this in perspective. Home medical equipment providers file supportive paperwork with their claims to the government so they can be reimbursed for power wheelchairs that have already been purchased from manufacturers and delivered to Medicare patients. If their claims are denied for lacking sufficient documentation of medical necessity or other reasons, most providers don’t retrieve the wheelchairs from the beneficiaries or get their money back from manufacturers. Thus, the providers *want* to be reimbursed for their investment and services that they delivered. In fact, one of their priorities is presenting the government with whatever documentation is required, so they can be paid and their businesses can continue operating.

Under these circumstances, Congress needs to seriously consider why 52 percent of claims would be ruled insufficiently documented? What does this say about the process for documenting medical necessity for power wheelchairs?

The answer is that the system is broken.

After CMS has continuously altered documentation requirements, it’s no surprise that physicians, clinicians, providers and beneficiaries remain confused about what it takes to demonstrate medical necessity.

CMS has used the absence of a creditable documentation process to make shifting and retroactive demands that the majority of physicians and providers say are unrealistic. In this age of technology, CMS requires that physicians make very detailed handwritten progress notes on their patients. Even more problematic, CMS has created an environment where auditors routinely overrule prescribing physicians and their clinical assessments of patients.

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For providers, this haphazard system means much more than just statistics in an OIG report. In real life, many of their reimbursement claims are denied, not because of questions related to whether the patient needed the power wheelchair, but because the physician documentation was not presented in the format that CMS desired. For instance, claim reviewers apply a literal interpretation of the term “written prescription.” CMS requires that a physician “write” a unique seven-element prescription only required for power wheelchairs.

Routinely, homecare equipment providers face guidelines that are retroactively applied to claims that were processed months, or even years, before the standards were adopted. The ramifications are severe, with many equipment suppliers facing excessive audits, claim denials that are often overturned upon appeal and payment delays that threaten their ability to continue providing power wheelchairs.

Respected physicians have joined the call for reform of this chaotic process.

“Some clinicians are shying away from performing wheelchair evaluations because the Medicare documentation process is such a burden,” said Mark R. Schmeler, PhD, OTR/L, ATP, who is an assistant professor in the Department of Rehabilitation Science & Technology at the University of Pittsburgh.

“Frankly, clinicians may believe their time is better spent on other types of therapy. Moreover, the documentation process becomes even more burdensome when a homecare provider is worried about the Medicare reimbursement process. The patient may have an obvious need for a power wheelchair, but the homecare provider asks that the documentation be modified or redone by the clinicians so that the case is stronger. This creates added frustration and delays. Clearly, there is a considerable gap between the intent of the documentation policy and the criteria utilized by auditors who search for any small or insignificant reason to deny claims.”

Furthermore, physicians are frustrated.

“Instead of helping me in my mission to keep my patients functional at home, CMS or Medicare throws stumbling blocks in my way at every turn it seems,” said Dr. Jerald Winakur, MD, FACP, CMD, the Clinical Professor of Medicine and an Associate Faculty member at the Center for Medical Humanities and Ethics at the University of Texas Health Science Center in San Antonio.

For other stakeholders, such as providers, manufacturers and consumer advocates, it’s disappointing when the OIG repeatedly publishes data that leads to misconceptions about the Medicare mobility benefit, and how it works. For instance, the OIG has reported on the price difference between power wheelchairs from home medical equipment providers and lower-priced Internet dealers. But their reports lost credibility by failing to note that the price comparison did not account for the level of service or quality of the products that the Medicare program requires of its accredited providers.

The trend continued with the release of the OIG report last week that didn’t cite the flawed documentation system as the reason why there was insufficient patient information to determine the medical necessity of so many claims.

AAHomecare’s Wilson called on CMS, the OIG and Congress to eliminate the root cause of the misconceptions by adopting a mandatory template that physicians would use to document a Medicare beneficiary’s medical necessity for a power wheelchair.

“Medicare patients and the government would be better served if CMS and the OIG looked at ways to fix the documentation process by providing the appropriate templates for physicians to demonstrate that a power wheelchair is needed by beneficiaries to improve their ability to function in their home and perform the daily necessities of life.”

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Mobility Matters is published periodically by the American Association for Homecare (AAHomecare) to inform Congress, the administration, policymakers, consumer organizations and the media about Medicare’s power mobility benefit, and the need to sustain it. AAHomecare is committed to helping seniors and people living with disabilities regain their freedom and independence. To learn more about the Medicare power mobility benefit, go to www.aahomecare.org/mobility.
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