TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

DURABLE MEDICAL EQUIPMENT

Inspection of Power Wheelchairs

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HHSC OIG
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Inspection of Power Wheelchairs

WHY THE OIG CONDUCTED THIS INSPECTION

The OIG conducted an inspection to determine if documentation requirements are being met when Medicaid clients receive power wheelchairs from durable medical equipment (DME) suppliers.

The inspection objectives were to determine if:

- DME suppliers meet documentation requirements for prior authorization for power wheelchairs.
- Clients receive power wheelchairs as prescribed.

The United States (U.S.) Department of Health and Human Services (HHS), Office of Inspector General issued a report, *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements*, to determine the extent to which standard and complex rehabilitation power wheelchair claims met Medicare documentation requirements and supplier proof-of-delivery standards. The U.S. HHS Office of Inspector General conducted a random sample of 375 Medicare claims and found 60 percent did not meet one or more documentation requirements for claims received in the first half of 2007.

The U.S. HHS Office of Inspector General presented at the National Association for Medicaid Program Integrity conference and reported DME, particularly power wheelchairs, had a potential for provider fraud, waste, and abuse. Common schemes addressed in the presentation included: (a) forging physician signatures on prescriptions, (b) substitution of lesser model power wheelchairs, and (c) billing used equipment as new.

View the report online at
https://oig.hhsc.texas.gov/
For more information, contact:
IG_Inspections_Division@hhsc.state.tx.us

WHAT THE OIG FOUND

Overall, the OIG Inspections and Investigations Division found documentation standards in the Texas Administrative Code for fee-for-service (FFS) claims, however, there are no documentation standards for managed care organizations (MCOs) when Medicaid clients receive power wheelchairs from DME suppliers. The Uniform Managed Care Contract allows each MCO to set their own standards for DME suppliers. MCOs have the discretion to require a prior authorization for power wheelchairs. Nine MCOs had documents included in the sample. Due to the cost of power wheelchairs, all nine of the MCOs sampled require prior authorizations.

The OIG made the following observations:

- Not all power wheelchairs were received as prescribed or used by clients in nursing facilities.
- A review of prior authorization and supporting documentation identified incomplete or inadequate information.

The OIG conducted on-site visits to determine if the identified clients received a new power wheelchair, as billed by DME suppliers, and found not all clients received power wheelchairs as prescribed. The OIG visited 40 clients and found 9 of them lived in nursing facilities. Of those nine, two stated they did not receive a power wheelchair, although the DME suppliers submitted the Title XIX form. Interviews and observations revealed six of the nine clients did not use their power wheelchairs in the nursing facility, although there was a Nursing Facility Custom Power Wheelchair authorization form for the six power wheelchairs. The Medicaid dollars associated with the two power wheelchairs not provided to clients totaled $32,521, while the total associated with the six power wheelchairs prescribed to clients, but not being used in the nursing facility totaled $114,324.

Complete and adequate information is critical in determining if a prior authorization form and its supporting documentation is accepted during the prior authorization process. All nine MCOs interviewed stated they require providers who submit prior authorization forms and supporting documents for DME to complete those forms in their entirety. The OIG determined that the content in the prior authorization forms is necessary for establishing the required medical necessity for DME and thereby used as a tool to prevent fraud, waste, and abuse in relation to the provision of power wheelchairs. If an MCO requires complete forms consistent with HHSC's prior authorization policy for FFS, submission and approval of an incomplete form missing critical information would demonstrate possible noncompliance with the prior authorization requirements.

The OIG reviewed 119 sets of prior authorization and supporting documentation and found 47 percent had at least one incomplete or inadequate piece of information missing from the DME supplier's documentation, which can be attributed to a total of $701,386 in expenditures for power wheelchairs. Of the 119 sets of prior authorization and supporting documentation received, 110 were from MCOs and 9 were from Texas Medicaid & Healthcare Partnership (TMHP). Of the 110 sets of documents received from MCOs, 20 percent had incomplete or inadequate information that was more critical in nature, such as prescriber name or contact information and documentation of date last seen by a physician. Those with more critical incomplete or inadequate information attributed to a total of $247,341 in expenditures for power wheelchairs. The OIG found no similar critical incomplete or inadequate information from the documentation received from TMHP.

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I. PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections and Investigations Division conducted an inspection to determine if documentation requirements are being met when Medicaid clients receive power wheelchairs from durable medical equipment (DME) suppliers. The inspection focused on the following objectives:

- Determine if DME suppliers meet documentation requirements for prior authorization for power wheelchairs.
- Determine if the clients receive power wheelchairs as prescribed.

II. BACKGROUND

The United States (U.S.) Department of Health and Human Services (HHS), Office of Inspector General issued a report, *Medicare Power Wheelchair Claims Frequently Did Not Meet Documentation Requirements*, to determine the extent to which standard and complex rehabilitation power wheelchair claims met Medicare documentation requirements and supplier proof-of-delivery standards.[1] The U.S. HHS Office of Inspector General conducted a random sample of 375 Medicare claims and found 60 percent did not meet one or more documentation requirements for claims received in the first half of 2007.[2]

The U.S. HHS Office of Inspector General presented at the National Association for Medicaid Program Integrity conference and reported DME, particularly power wheelchairs, had a potential for provider fraud, waste, and abuse.[3] Common schemes addressed in the presentation included: (a) forging physician signatures on prescriptions, (b) substitution of lesser model power wheelchairs, and (c) billing used equipment as new.

The Texas HHS OIG Inspections and Investigations Division initiated this inspection to determine if Medicaid prior authorization and supporting documentation requirements from DME suppliers and prescribing providers were approved, as required by the managed care organizations (MCOs) for managed care claims and Texas Medicaid & Healthcare Partnership (TMHP) for fee-for-service (FFS) claims. The OIG performed a data query indicating more than $11 million was spent on new power wheelchairs and accessories in FFS and managed care combined in fiscal year 2017. Table 1 shows the breakdown of FFS and MCO

[1] December 2009, Report OEI-04-07-00401, https://oig.hhs.gov/oei/reports/oei-04-07-00401.pdf
[2] For standard and complex rehabilitation power wheelchair clients.
[3] August 2017, National Healthcare Fraud Trends Presentation, https://drive.google.com/file/d/0B4cH5XNafuimZC03S1hIZ29XbmM/view

expenditures for new power wheelchairs and accessories in fiscal year 2017.

Table 1: FFS and MCO Power Wheelchair Expenditures FY17

FFS	$ 933,011
MCO	$10,281,082
Total:	**$11,214,093**

Source: OIG Data and Technology (DAT), FFS: Vision 21- AHQP Universe; MCO: Vision 21-Encounters Best Picture Universe

Prior Authorization Documentation for Power Wheelchairs

TMHP uses the Texas Medicaid Provider Procedures Manual (TMPPM) for policy and procedure guidance and Chapter 354 (Medicaid Health Services) of the Texas Administrative Code (TAC), which sets the standards for FFS claims.[4] The TMPPM requires providers to use all of the following documentation for FFS claims:

1. *Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form* for prior authorization of standard and custom power wheelchairs for FFS claims.[5]
2. *Nursing Facility Custom Power Wheelchair Authorization Form*, if the client is a resident within a nursing facility and is in need of a power wheelchair. The *Seating Assessment* is included with this form if the power wheelchair includes major modifications.
3. *DME Certification and Receipt Form*, submitted by DME suppliers prior to reimbursement for FFS claims. DME suppliers are required to use the form for power wheelchairs that meet or exceed a billed amount of $2,500.[6] The certification form requires: (a) the date on which the client receives the power wheelchair, (b) item name with serial number, and (c) signatures of the DME supplier and the client or primary caregiver. The client's signature reflects the DME is the property of the client.

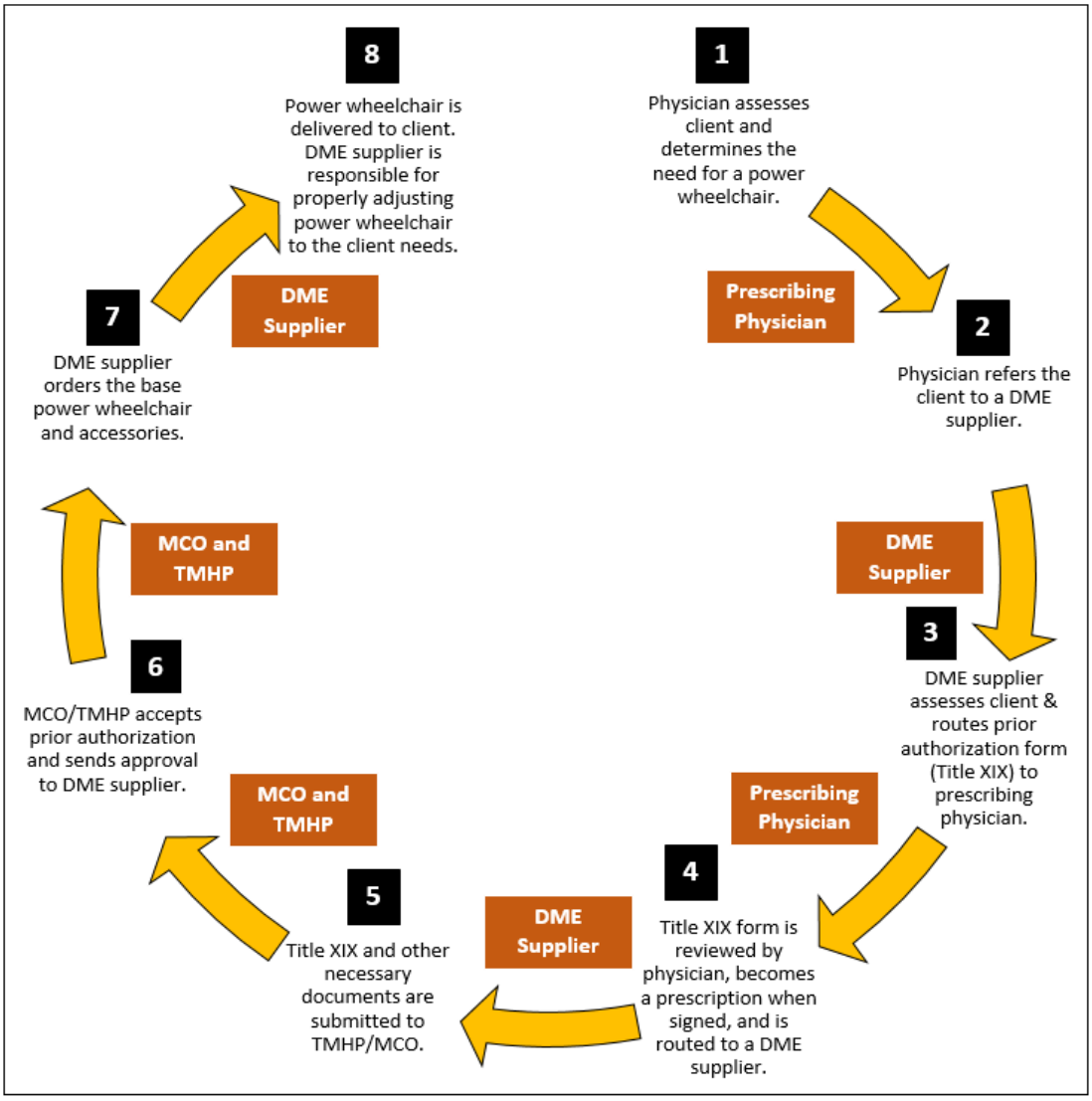
MCOs are generally exempt from Chapter 354 of the TAC.[7] Each MCO has its own requirements to determine the documentation needed to satisfy prior authorization of a power wheelchair. Nine MCOs had documents included in the sample. All nine MCOs require prior authorization and allow providers to use the Title XIX form, Nursing Facility Custom Power Wheelchair authorization, and Seating Assessment form from the TMPPM. Although the DME Certification and Receipt form is

[4] 1 Tex. Admin. Code § 354.1039 and § 354.1040
[5] TMPPM, Volume 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook," Section 2.2.1, Jan. 2017
[6] TMPPM, Volume 2, "Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook," Section 2.2.2, Jan. 2017
[7] 1 Tex. Admin. Code § 353.1(d)

required for FFS claims, it is not required for MCOs and the nine MCOs sampled did not use this form.

Even though MCOs require prior authorization and allow providers to use the forms required for FFS claims, the Uniform Managed Care Contract (UMCC) does not require MCOs to use these forms. Additionally, there are no set standards in the UMCC or the Uniform Managed Care Manual regarding how the forms should be completed by the DME suppliers and prescribing providers. MCOs may elect to use the TMPPM as a guideline, but are not required to follow the TMPPM standards when completing or using forms for managed care claims.

Figure 1: Example of DME Power Wheelchair Payment and Documentation Flow in Texas Managed Care



Source: OIG Inspections and Investigations Division, research of prior authorization process

Referrals Identified During Inspection

Of the 10 DME suppliers reviewed, the OIG Inspections and Investigations Division referred 3 to the HHSC OIG Medicaid Program Integrity (MPI) Division for preliminary investigation. The OIG Inspections and Investigations Division referred the remaining seven DME suppliers to HHSC OIG Medical Services for review of prior authorization and supporting documentation.

The OIG Inspections and Investigations Division referred 13 prescribing providers to the Texas Medical Board due to possible violation of 22 Tex. Admin. Code § 165.1 for failure to maintain the Title XIX or Nursing Facility Custom Power Wheelchair authorization form within a client's medical record.[8]

[8] 22 Tex. Admin. Code § 165.1 is a Texas Medical Board rule that requires contents of an "adequate medical record."

III. INSPECTION RESULTS

Overall, the OIG Inspections and Investigations Division found documentation standards in TAC for FFS claims, however, there are no documentation standards for MCOs when Medicaid clients receive power wheelchairs from DME suppliers. The UMCC allows each MCO to set their own standards for DME suppliers. MCOs have the discretion to require a prior authorization for power wheelchairs. Due to the cost of power wheelchairs, all nine of the MCOs sampled require prior authorizations.

The OIG Inspections and Investigations Division conducted on-site visits to determine if the identified clients received a new power wheelchair, as billed by DME suppliers, and found not all clients received power wheelchairs as prescribed.[9] Of the nine clients living in nursing facilities, two stated they did not receive a power wheelchair, although the DME suppliers submitted the Title XIX form, and six clients did not use their power wheelchairs in the nursing facility, although there was a Nursing Facility Custom Power Wheelchair authorization form. The Medicaid dollars associated with the two power wheelchairs not provided to clients totaled $32,521, while the total associated with the six power wheelchairs prescribed to clients, but not being used in the nursing facility totaled $114,324.

Complete and adequate information is critical in determining if a prior authorization form and its supporting documentation is accepted during the prior authorization process. All nine MCOs interviewed stated they require providers who submit prior authorization forms and supporting documents for DME to complete those forms in their entirety. The OIG determined that the content in the prior authorization forms is necessary for establishing the required medical necessity for DME and thereby used as a tool to prevent fraud, waste, and abuse in relation to the provision of power wheelchairs. If an MCO requires complete forms consistent with HHSC's prior authorization policy for FFS, submission and approval of an incomplete form missing critical information would demonstrate possible noncompliance with the prior authorization requirements.

The OIG reviewed 119 sets of prior authorization and supporting documentation and found 47 percent had at least one incomplete or inadequate piece of information missing from the DME supplier's documentation, which can be attributed to a total of $701,386 in expenditures for power wheelchairs.[10] Of the 119 sets of prior authorization and supporting documentation received, 110 were from MCOs and 9 were from TMHP. Of the 110 sets of documents received from MCOs, 20 percent had incomplete or inadequate information that was more critical in nature, such as

[9] See Appendix A: Detailed Methodology.

[10] A "set" is defined as a distinct client record containing documents related to the purchase of their power wheelchair.

prescriber name or contact information and documentation of date last seen by a physician. Those with more critical incomplete or inadequate information attributed to a total of $247,341 in expenditures for power wheelchairs. The OIG found no similar critical incomplete or inadequate information from the documentation received from TMHP.

Observation 1: Not all power wheelchairs were received as prescribed or used by clients in nursing facilities.

The OIG Inspections and Investigations Division conducted on-site visits to determine if the identified clients received a new power wheelchair, as claimed by DME suppliers, and found not all clients received power wheelchairs as prescribed.[11] The OIG visited 40 clients and found 9 of them lived in nursing facilities. Of those nine, two stated they did not receive a power wheelchair, although the DME suppliers submitted the Title XIX form. Interviews and observations revealed six of the nine clients did not use their power wheelchairs in the nursing facility, although there was a Nursing Facility Custom Power Wheelchair authorization form for the six power wheelchairs.

Observation 2: A review of prior authorization and supporting documentation identified incomplete or inadequate information.

The OIG uses documentary evidence when reviews are conducted on providers for possible fraud, waste, and abuse. The OIG reviews prior authorization forms and supporting documents to determine if information is incomplete or altered.

Incomplete or Inadequate Forms

The OIG Inspections and Investigations Division reviewed 119 sets of prior authorization and seating assessment forms; 110 were from MCOs and 9 were from TMHP. Of the 119 sets of forms reviewed, the OIG found 47 percent had at least one incomplete or inadequate piece of information missing from the DME supplier's documentation. Of the 110 sets of prior authorization and seating assessment forms received from MCOs, 20 percent had incomplete or inadequate information that was more critical in nature, such as prescriber name or contact information and documentation of date last seen by a physician; however, the authorizing MCO approved the prior authorization. Of the nine sets of documentation received from TMHP, the OIG found no similar critical incomplete or inadequate information that would affect the prior authorization approval.

[11] See Appendix A: Detailed Methodology.

Comparison Review of MCO and Prescribing Physician Prior Authorization Forms

The OIG Inspections and Investigations Division conducted a comparison review of the requested prior authorization forms from the MCOs and the prescribing physician's retained copy.[12] Of the 110 sets of MCO prior authorization forms reviewed, 3 had discrepancies. One prescribing provider reviewed a copy of a Title XIX form and reported the signature documented on the form was not the provider's; and two Title XIX forms did not match the prescribing physician's retained Title XIX form. Of the two unmatched Title XIX forms, one form contained additional power wheelchair accessories not listed on the prescribing physician's copy, and the other form noted a different DME supply company than what the prescribing physician's retained document annotated. The OIG Inspections and Investigations Division referred these three discrepancies to MPI for preliminary investigation.

[12] See Appendix A: Detailed Methodology.

IV. CONCLUSION

The OIG Inspections and Investigations Division completed an inspection to determine if documentation requirements are being met when Medicaid clients receive power wheelchairs from DME suppliers. Overall, the OIG Inspections and Investigations Division found documentation standards in TAC for FFS claims, however, there are no documentation standards for MCOs when Medicaid clients receive power wheelchairs from DME suppliers. The UMCC allows each MCO to set their own standards for DME suppliers. MCOs have the discretion to require a prior authorization for power wheelchairs. Due to the cost of power wheelchairs, all nine of the MCOs sampled require prior authorizations.

The OIG Inspections and Investigations Division made the following observations:

- Not all power wheelchairs were received as prescribed or used by clients in nursing facilities.
- A review of prior authorization and supporting documentation identified incomplete or inadequate information.

The OIG Inspections and Investigations Division referred three of the DME suppliers reviewed to HHSC OIG MPI for preliminary investigation and seven to HHSC OIG DMS for review of prior authorization and supporting documents. Even though MCOs may use prior authorization forms required of FFS claims, the MCOs are not required to use these forms. However, if the MCO uses the forms, the forms are required to be completed in their entirety by the providers.

There were 13 prescribing provider referrals generated to the Texas Medical Board due to possible violation of 22 Tex. Admin. Code § 165.1, for failure to maintain the Title XIX or Nursing Facility Custom Power Wheelchair authorization form within a client's medical record.[13]

The OIG Inspections and Investigations Division thanks the Texas Medicaid & Healthcare Partnership, the managed care organizations, the nursing facilities, and interviewed clients for their cooperation and assistance during this inspection.

[13] 22 Tex. Admin. Code § 165.1 is a Texas Medical Board rule that requires contents of an "adequate medical record."

V. APPENDICES

Appendix A: Detailed Methodology

A population of power wheelchair providers was generated by OIG DAT. This population consisted of 25 DME suppliers who Medicaid reimbursed for at least 10 base power wheelchairs in fiscal year 2017. DAT ranked the DME suppliers by the number of claims and separated into two groups: the top 10 DME suppliers were grouped into "high volume providers" and the remaining 15 were grouped into "low volume providers." A sample of 5 providers was randomly selected from each group to make a final sample of 10 providers. DAT then randomly selected 12 claims from each provider and the final sample consisted of 120 claims.

The OIG Inspections and Investigations Division requested 120 prior authorization forms and supporting documents from the FFS and managed care providers based on the random sample performed by OIG DAT. One MCO was unable to locate a client's prior authorization. The inspection team also requested 119 prior authorization forms from prescribing physicians, of which only 60 percent were received. The OIG Inspections and Investigations Division reviewed the prior authorization forms, supporting documents, and the prior authorization forms retained by the prescribing physician.

In May and June 2018, OIG DAT provided the team a randomly selected sample of 62 client on-site inspections for the Austin, San Antonio, Houston, and Dallas areas. The inspection team planned to visually inspect and record each of the 119 client's power wheelchair serial numbers, along with interviewing each client regarding the receipt of their power wheelchair from the DME supplier. Only 40 of the 119 clients were available for the on-site inspections.

Standards

The OIG Inspections and Investigations Division conducts inspections of the Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspections typically result in observations and may result in recommendations to strengthen program effectiveness and efficiency. The OIG Inspections and Investigations Division conducted the inspection in accordance with Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this OIG Inspections and Investigations Division report include:

- Lisa Campos Garza, CFE, CGAP, Director for Inspections
- Xavier Ortiz, Manager for Inspections
- Dennis Barker, Team Lead for Inspections
- James Aldridge, Inspector
- Levi Martinez, Inspector
- Jill Townsend, Inspector
- Kenin Weeks, Inspector
- Coleen McCarthy, MS, CHES®, Editor
- Laura Cadena, Investigative Data Analyst
- Xiaoling Huang, Chief Statistician for Data and Technology
- Junqun Xiong, Statistical Analyst for Data and Technology

Report Distribution

Texas Health and Human Services:

- Courtney N. Phillips, PhD, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Enrique Marquez, Chief Program and Services Officer
- Wayne Salter, Deputy Executive Commissioner, Access and Eligibility Services
- Stephanie Muth, Deputy Executive Commissioner, Medicaid and CHIP Services
- Karin Hill, Director, Internal Audit

Appendix C: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, review, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Anita D'Souza, OIG Chief Counsel and Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief Strategy Officer
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Knobloch, Assistant Deputy IG for Medical Services

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To report fraud, waste, and abuse in Texas HHS programs

- Online: https://oig.hhsc.texas.gov/report-fraud
- Phone: 1-800-436-6184

To contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
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