Wheelchair Provider: Medicare Bidding Program is a Sham

(This is a special edition of DME Matters. Carl A. Mulberry, president of Columbus Medical Equipment, has written an emotional letter to Congress about how the Medicare bidding program is adversely affecting the lives of Medicare patients, as well as his and other businesses. His focus is on just one of the many absurd aspects of the program—the process for Medicare patients with broken mobility equipment to get repairs. It is a troubling story of bad policy creating bad results for some of the most vulnerable people in our society. We’re sharing his letter with readers of DME Matters, so they can better understand how the bidding program is hurting the health of Medicare patients and ruining good businesses.)

Dear Congress,

Columbus Medical Equipment is the largest repair center in central Ohio for manual and power drive wheelchairs. We have been serving central Ohio since 1975, and we have the largest wheelchair parts inventory in the state. We know wheelchairs.

The trend in the last few years is for Medicare, as well as private insurance companies, to close markets for home medical equipment and repairs by only allowing a limited number of suppliers to service patients. The Medicare bidding program does this, as do various other insurers, who impose fixed prices on goods and services. This year, we are experiencing a substantial increase in this method of providing mobility products (and healthcare). We are now unable to serve a significant portion of our former market.

The tactics that CMS has used to reduce access to mobility equipment is indeed saving money, but at what cost to the vulnerable seniors and people with disabilities that the Medicare program is supposed to care about? In our service area, many Medicare patients are not getting mobility equipment and repairs that would have been provided in the past. A large number of them are not able to find suppliers willing to accept Medicare’s below market rate reimbursement for wheelchair repairs.

Providing wheelchairs through Medicare has become a gamble for suppliers. The supplier must make the determination of whether a patient qualifies for equipment. We must base our decision on our interpretation of subjective rules that are constantly revised by CMS. If we misinterpret these rules, we find out by denial of payment, pre-payment audits, or post-payment audits. We’re constantly trying to stay ahead of the changes that reviewers and auditors make when interpreting the rules. Still, we usually learn the hard way; non-payment for hard work and expensive equipment.

Every patient is a gamble. We provide products and services and hope that the paperwork we have gathered passes muster.

Gathering the paperwork has become extensive and excessive. This is how CMS has chosen to limit access and cut costs. It has become the responsibility of the supplier to badger, cajole, and hassle the physicians, therapists, and medical professionals to create documentation that exactly matches the wording that must be used to try to convince reviewers that the patient does indeed qualify for the wheelchair that was prescribed.

Whether or not a person really qualifies for a better manual chair or a power drive chair is often fraught with subjective opinion. As a businessman and not a gambler, I do not care who makes this
I just wish that I wasn’t the one being punished when the patient’s physician gets second-guessed by reviewers and auditors.

CMS has completely eliminated wheelchair repairs for many patients. They have set up an airtight Catch-22 with the implementation of their badly flawed bidding program.

First, most of the suppliers that won bids have never done repairs. Most of the contracted suppliers in our market area do not have the parts, staff, or abilities to do repairs within any reasonable time frame. These contract suppliers have told patients, who I have had to turn away because I am not contracted, that they are not doing any repairs for chairs that they did not provide.

Second, Medicare has lowered the payment rates for parts and accessories that were bid, to the contracted amounts. Even though I did not bid or agree to these low amounts, I must accept these payment rates if I choose to accept payment from Medicare. Since these extremely low payment amounts are below my actual cost for most of the parts, I have chosen, in many cases, not to accept assignment. When this happens, I am required to refer the patient to a contract supplier or a supplier who is willing to accept the bid payment amount. As you can imagine, I have angered many of my valued customers.

Third, I can only offer some parts and service on wheelchairs that fall under the bidding program. I am not allowed to provide certain assemblies (like complete armrests). These items must be provided by contracted suppliers. Most wheelchairs needing repair did not come from bid winners. Therefore, before a contracted supplier can ask for payment for the assembly, they must qualify the patient for the chair.

Qualification is an arduous process that requires the patient to go to a physician for a face-to-face visit that the doctor documents in his/her chart notes. Usually, the doctor will then send the patient to a clinic where medical professionals (independent of the supplier) create a thorough and exacting evaluation designed to answer qualification questions required by CMS. Getting into these clinics can take weeks or months. After the evaluation is completed and the doctor concurs with the therapist's findings, the doctor must write an order that has eight specific elements. The supplier then presents a form called a detailed product description to the doctor for signature and date. All of the steps in this process must line up correctly. And, all of them must be done within a specific time frame.

I do not know of any independent physicians or therapists in my market area that are willing or able to accept Medicare payment for these extensive evaluations. We must refer all of our Medicare patients to one of the few clinics that are supported by our largest institutions. All of our area suppliers have had to ask these institutions to help us with the Medicare evaluation process. Many times these clinics are not reimbursed for the evaluations. They run into caps and duplicate services rules, and they run the risk of being audited for their billings. This is why independent therapists or small facilities cannot afford to perform these evaluations.

The Scooter Store was the largest supplier of power drive wheelchairs in the United States for several years. Most of their chairs were funded (fully or partially) by Medicare. Some patients had conditions that qualified them under Medicare guidelines and some did not. Many of their patients called us for repairs before, and even more call now that The Scooter Store has gone bankrupt. It’s a rude awakening when we explain to these patients that they must now deal with a supplier approved under the bidding program. We then give them the full list of contract suppliers in our market area. Quite often, they call us back asking what they should do because they found, after making all of the calls, that they will need to be re-qualified for their chair to get it repaired, and that they may not qualify under the new guidelines. They will have to go through the above process even to get the tiniest of parts. I think we can all agree that this is absolutely absurd and needs to stop!
All of this is supposedly saving Medicare money. How is that even possible? They have made it more difficult for Medicare patients to obtain power wheelchairs that help keep the cost of healthcare down. Compare, in your mind, the low cost of keeping people mobile in their homes to the high cost of sending them to care facilities and hospital emergency rooms.

A long-time patient called me last week. She was almost in tears because her hospital bed has needed repair for quite a long time. The bed needs an accessory replaced; the foot motor and tube assembly, which is part of the bidding program. She had called several contract suppliers to try to get help. She finally found one that charged her $60.00 to come to her home and identify what needed replacing. When she did not hear back, she called them and was told that they were not able to find the parts for her bed. She has one of the most common beds in the homecare industry. She is now planning to buy the part from us and have a friend’s son install it for her. Medicare successfully saved money on this case. And this is supposed to be a good thing? What’s the cost of the anxiety that this women was needlessly put through?

Another long-time patient uses a scooter for mobility. She has made calls all over central Ohio trying to get someone to repair her scooter. After several weeks of this, and exasperated by the experience, she contacted her congressman. She was told that his office would call us. His state office never called. We then got a call from a state waiver program offering to authorize repair of her scooter. We had to explain to her that before we accept any waiver payment we must obtain a denial from Medicare. We cannot get a denial from Medicare because this is a “covered service” in the bidding program. Does this sounding like a run-around? She has still not gotten her scooter repaired. Medicare saves money when people don’t have access.

Six to twenty times every business day since July (when the bidding program was implemented here) we have given Medicare patients the phone numbers of contract suppliers. So far, about fifty percent of those callers call us back, frustrated with the phone work that they had just been through. They then choose to forgo their Medicare benefits, and buy their mobility aid from us. Medicare saves a lot of money when these people give up on their benefits.

There are a substantial number of Medicare patients that also have Medicaid. This population is being hurt the most. They are our silent sufferers. Few of these people have the desire or wherewithal to fight “the hand that feeds them.” I am not allowed to take payment from them for so-called “covered repairs.” When the repair costs are not really covered, my choice is to do the repair free (or partially free by accepting inadequate reimbursement) or refuse service and turn them away. I have to turn away more patients than ever before. All suppliers have been doing free service for these types of patients for years. One reason we are in this mess is our common enabling of our payors to take well deserved reimbursement from us. Medicare saves money when I give products and services away free.

I believe we should all do our part to preserve Medicare and the good things it does for us. It hurts my heart to witness seniors and the disabled community forced to contribute a disproportionate share when they silently forgo their benefits or get pushed into the Catch-22 qualification process. For many patients in central Ohio, there is no access to a Medicare repair benefit.

Carl A. Mulberry, ATP, CRTS
President
Columbus Medical Equipment
DME Matters is published periodically to inform Congress, the administration, policymakers, consumer organizations, and the media about the dangers of Medicare’s bidding program for home medical equipment. To learn more about the effort to end this dangerous and defective procurement process, visit www.aahomecare.org or contact Peter Rankin at 202-372-0755 or peterr@aahomecare.org.

American Association for Homecare
1707 L Street NW, Suite 350
Washington, D.C. 20036
info@aahometcare.org
202.372.0107