

# Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

## SUPPLIER INFORMATION

Supplier Type:

Supplier Number: 0500640003

Supplier Name: WHEELCHAIR AND WALKER  
RENTALS INC

National Provider Identifier(NPI): 1134763014

Authorized Representative: JOGALE COULTER

Telephone Number: 9155447144

Address: 1241 N LEE TREVINO DR

City/State/Zip Code: El Paso, TX 79907

Reason for Visit: Revalidation

## VISIT DATES

Date of First Visit

12/12/2023



Time of First Visit

11:00 AM

Date of Second Visit



Time of Second Visit

## FACILITY INFORMATION

1. Type of Facility

Storefront

☒ Yes

☐ No

Suite-Mall/Plaza

☐ Yes

☒ No

Suite-Office Building

☐ Yes

☒ No

Private Residence

☐ Yes

☒ No

**Warehouse (Only)**

- ☐ Yes  
☒ No

**Other**

- ☐ Yes  
☒ No

**Attach Photo**

- ☒ Yes  
☐ No

**Photo Upload**



Latitude: 31.7382471  
Longitude: -106.3262145  
Date: 12/12/2023 11:04 AM MST

**Office-Warehouse Attached**

- ☐ Yes  
☒ No

**If "Other", Please Describe**

**a. What is the approximate size of the facility?**

7000 Square Feet

**b. Is access to facility restricted (gated community, call box, etc)?**

- ☐ Yes  
☒ No

c. Are there customers or signs of business activity during the inspection?

- ☒ Yes  
☐ No

d. Is this facility normally visited by beneficiaries?

- ☒ Yes  
☐ No

e. If a home based business, are all local zoning requirements met?

- ☐ Yes  
☐ No  
☒ N/A

2. Is the facility accessible to the disabled?

- ☒ Yes  
☐ No

If "No", how does the supplier accommodate disabled persons?

Attach Photo

- ☒ Yes  
☐ No

### Photo Upload



Latitude: 31.7382471  
Longitude: -106.3262145  
Date: 12/12/2023 11:05 AM MST

3. Is there a permanent, visible sign with the supplier's business name posted on the facility?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 0749. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244- 1850.

4. Are hours of operation posted?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



Latitude: 31.7382471  
Longitude: -106.3262145  
Date: 12/12/2023 11:06 AM MST

Open 24/7 (Open 24 hours a day, 7 days a week)

OR

☐ Yes

☒ No

By Appointment Only (no fixed days or hours)

AND/OR

☐ Yes

☒ No

Please list hours of operation below

Monday

8:00 AM to 5:00 PM

Tuesday

8:00 AM to 5:00 PM

Wednesday

8:00 AM to 5:00 PM

Thursday

8:00 AM to 5:00 PM

Friday

8:00 AM to 5:00 PM

Saturday

Closed

**Sunday**

Closed

**Total Hours**

45 Hours

5. Was the site visit completed? If unable to conduct site visit for any reason (supplier not operational or inspection refused), please explain in the Additional Comments section at the end of this form.

- ☒ Yes  
☐ No

**INTERVIEW OF INDIVIDUAL(S) PRESENT**

6. Individual(s) Interviewed

- ☐ Owner  
☐ President  
☒ Manager  
☐ Administrator  
☐ Other

**Owner's Last Name**

**Owner's First Name**

**President's Last Name**

**President's First Name**

**Manager's Last Name**

Coulter

**Manager's First Name**

Jody

**Administrator's Last Name**

**Administrator's First Name**

**If "Other", Please Describe**

**Additional Information**

Jody Coulter is the Chief Operating Officer and the Chief Financial Officer.

7. The supplier must provide a list of all owners and management with day-to-day control, including name and title.

**Attach Copy**

- ☐ Yes  
☒ No

8. Does the supplier have other locations that service Medicare beneficiaries? If additional space is needed, please use the Additional Comments section at the end of this form.

- ☐ Yes  
☒ No

If "Yes", please supply the following items:

**Business Name**

**Address**

**City**

**State**

**Zip Code**

**PTAN**

9. Does the owner or any relatives own(ed) any other medical entities? If additional space is needed, please use the Additional Comments section at the end of this form.

- ☒ Yes  
☐ No

If "Yes", please supply the following items:

**Owner's Last Name**

**Owner's First Name**

**Relationship**

**Business Name**

**Address**

**City**

State

Texas

Zip Code

79907

10. Does the supplier share office space with other DME suppliers or other medical businesses?

- ☐ Yes  
☒ No

If "Yes", please supply the following items:

Business Name

Type of Business

Owner's Last Name

Owner's First Name

Attach Photo

- ☐ Yes  
☒ No

Do the co-located businesses share any of the following items?

a. Entrances

b. Office personnel/ownership

- ☐ Yes  
☐ No

- ☐ Yes  
☐ No

c. EIN

d. Telephone

- ☐ Yes  
☐ No

- ☐ Yes  
☐ No

e. Inventory

- ☐ Yes  
☐ No

If "Yes" to any of the above, please describe and attach photos.

RECORDS & TELEPHONE

11. Are the patient records maintained (check all that apply)

at this location?

- ☒ Yes  
☐ No

at an off-site storage facility?

- ☐ Yes  
☒ No

electronically?

- ☒ Yes  
☐ No

a) Do these records include physician ordering/referral documentation?

- ☒ Yes  
☐ No

b) Do these records include beneficiary communications, such as questions received from beneficiaries and progress notes?

- ☒ Yes  
☐ No

c) Do these records include documentation of delivery?

- ☒ Yes  
☐ No

d) Do these records include documentation of maintenance, repairs, or exchanges?

- ☒ Yes  
☐ No

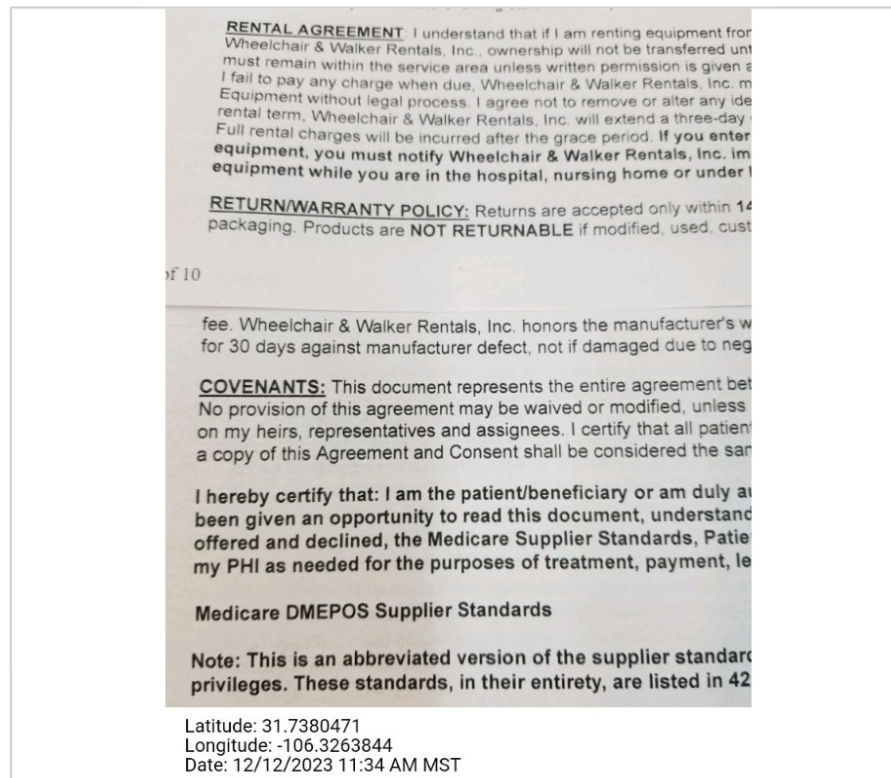
e) Do these records include proof the supplier provided equipment warranty?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



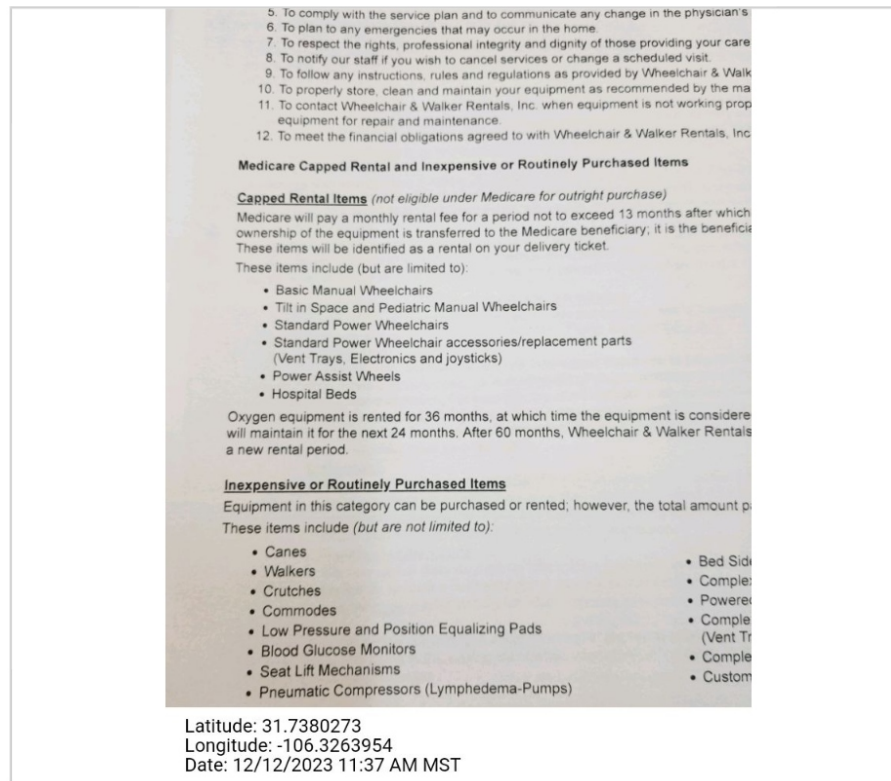
f) Do these records include proof the supplier advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased equipment, and of the capped rental policy?

Attach Photo

- ☒ Yes
- ☐ No

- ☒ Yes
- ☐ No

## Photo Upload



g) Do these records include proof the supplier provides beneficiaries with written information and instructions on how to use Medicare covered items safely and effectively?

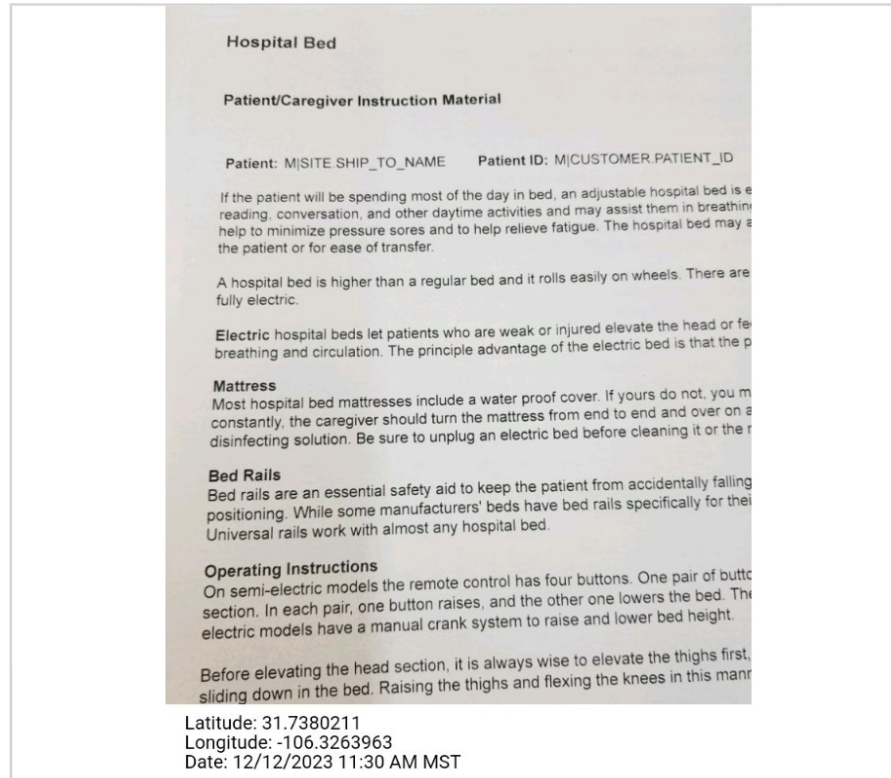
- ☒ Yes  
☐ No

If "No" to any of the above, please explain

## Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



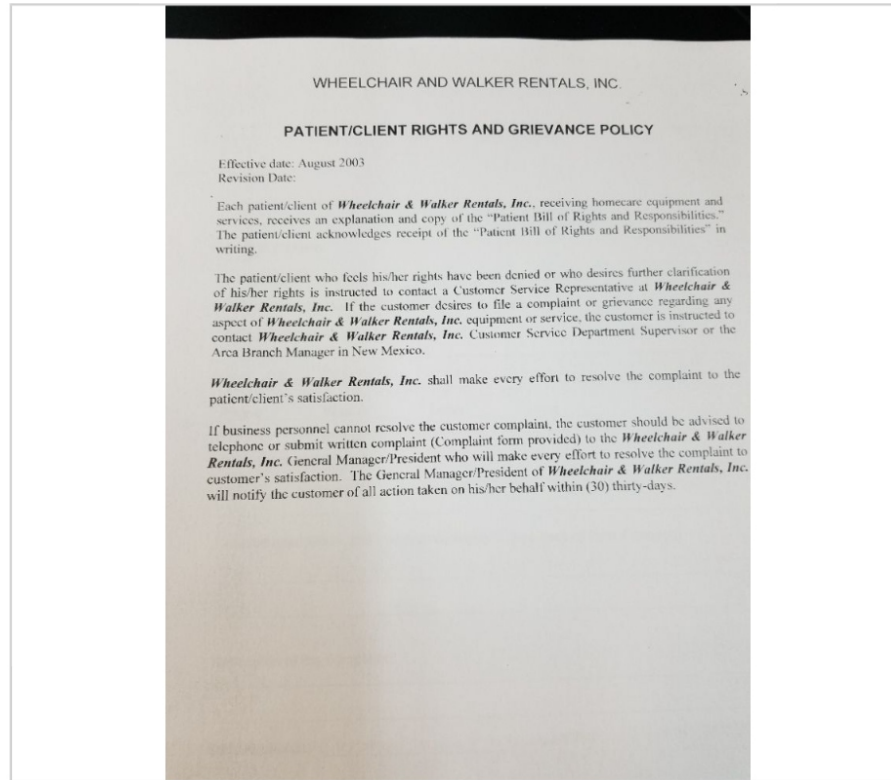
12. Does the supplier have a written complaint policy/procedure established and document for logging complaints?

- ☒ Yes  
☐ No

If "Yes", please attach a copy of their complaint policy and complaint log.

- ☒ Yes  
☐ No

### Complaint Log Photo Upload



### Complaint Log Photo Upload

[illegible]

13. Does the supplier have a business phone number (other than a cellular phone) listed in a local telephone directory under the business name?

- ☒ Yes  
☐ No

Please list the phone number

(915) 544-7144

a) How was the phone number verified (check all that apply)?

White/Yellow Pages

- ☐ Yes  
☒ No

Directory Assistance

- ☒ Yes  
☐ No

b) Was there telephone activity during the site inspection?

- ☒ Yes  
☐ No

#### LICENSING/CERTIFICATION

14. Are the supplier's business, customers, and employees covered by comprehensive liability insurance? (Obtain current certificate of insurance with NSC as the certificate holder.)

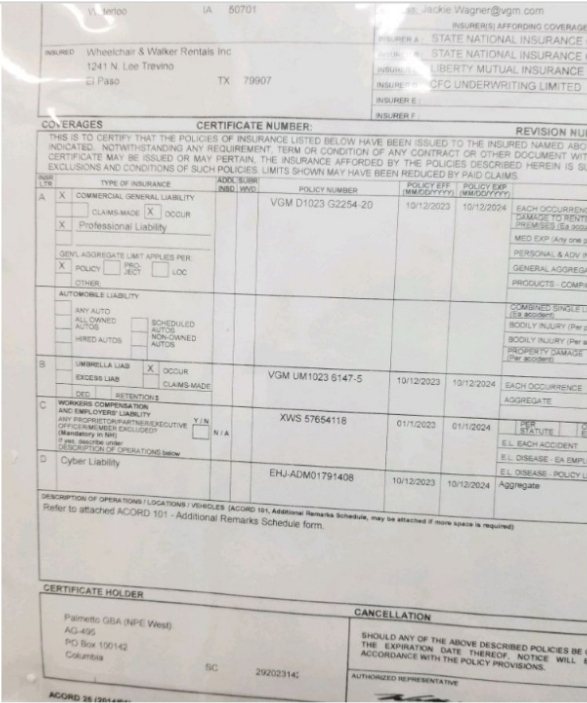
- ☒ Yes  
☐ No

If "No", please describe

Attach Photo

- ☒ Yes  
☐ No

Photo Upload



Latitude: 31.7381649  
Longitude: -106.3261022  
Date: 12/12/2023 11:18 AM MST

15. Does the supplier have valid state and federal licenses applicable to their business?

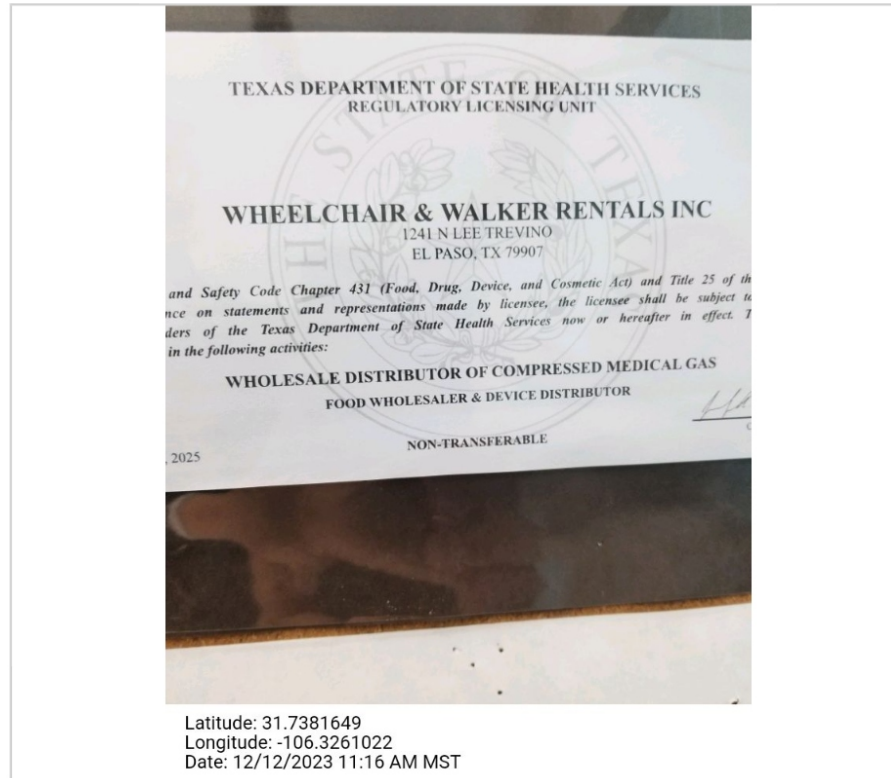
If “No”, please describe

- ☒ Yes
- ☐ No

Attach Photo

- ☒ Yes
- ☐ No

## Photo Upload



16. Does the supplier provide custom fitted or fabricated Orthotic and Prosthetic items?

- ☐ Yes
- ☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes
- ☒ No

a) Does the supplier fabricate items onsite?

- ☐ Yes
- ☒ No

If "No", does the supplier contract with other companies for the purchase of items necessary to fill orders?

- ☐ Yes
- ☒ No

If "Yes", please identify the company:

Company Name

Street Address

City

State

Zip Code

Telephone #

17. Does the supplier provide diabetic footwear?

- ☐ Yes  
☒ No

If "Yes", what are the name(s) and qualifications of those providing this service?

Attach Photo

- ☐ Yes  
☒ No

18. Does the supplier provide oxygen or oxygen related equipment?

- ☒ Yes  
☐ No

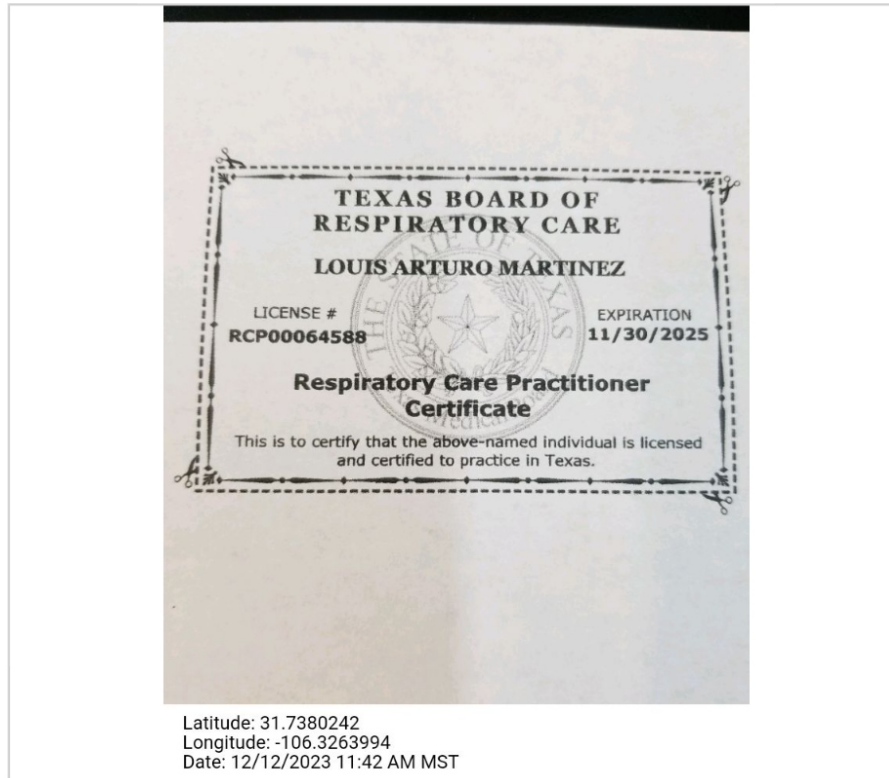
If "Yes", what are the name(s) and qualifications of those providing this service?

Louis Martinez is a Certified Respiratory Care Practitioner.

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



## INVENTORY

19. Does the supplier have inventory stored on site?

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

Briefly provide description of inventory present

The supplier stocks canes, wheelchairs, electric wheelchairs, scooters, walkers, oxygen concentrators, and related supplies.

## Photo Upload



Latitude: 31.7381649  
Longitude: -106.3261022  
Date: 12/12/2023 11:09 AM MST

20. Does the inventory present support the supplier's billing history?

- ☐ Yes  
☒ No

N/A (No billing history)

Yes

a) If "No", please obtain invoices and/or contracts to verify the purchase of DME supplies.

- ☒ N/A  
☐ Attach Photo

Vendor Name

Street Address

City

State

Zip Code

Telephone #

b) Does the supplier maintain an off-site storage facility?

- ☐ Yes  
☒ No

If "Yes", please provide

Street Address

City

State

Zip Code

c) Does the supplier accept other types of health insurance?

- ☒ Yes  
☐ No

If "Yes", please list

The supplier accepts most private health insurance plans, including Amerigroup, Blue Cross Blue Shield, Cigna, Humana, Molina, Presbyterian, United Healthcare, and WellMed.

21. Does the supplier rent Durable Medical Equipment?

- ☒ Yes  
☐ No

a) If "Yes", does the supplier directly service, maintain or replace DME items it rents to beneficiaries?

- ☒ Yes  
☐ No

b) Do they have a service contract with another supplier?

- ☐ Yes  
☒ No

If "Yes", please identify the company

- ☐ Yes  
☐ No

Company Name

Street Address

City

State

Zip Code

Telephone #

If "No" to any of the above, please provide an explanation:

The supplier provides all equipment maintenance and repair in-house.

Attach Photo

- ☐ Yes  
☒ No

#### CONTACT WITH BENEFICIARY

22. Is a copy of the current Supplier Standards provided to all Medicare patients?

- ☒ Yes  
☐ No

23. Does the supplier directly solicit (or utilize any third-party vendors to solicit) beneficiary referrals via telephone?

- ☐ Yes  
☒ No

If "Yes" to third-party vendor, list company name(s).

If "No", please describe what methods the supplier uses to obtain new customers?

Notes

The supplier obtains new customers by referral from doctors' offices and medical facilities.

24. Does the supplier furnish contact information to beneficiaries at the time of delivery? Example: an equipment sticker label listing the supplier's name and telephone number

- ☒ Yes  
☐ No

Attach Photo

- ☒ Yes  
☐ No

## Photo Upload



25. Does the supplier accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries?

- ☒ Yes  
☐ No

If "No", explain the reasons why

## SIGNATURE AND DECLARATION

### Additional Comments

Question 9, Jody Coulter, Chief Operating Officer and the Chief Financial Officer, stated that Wheelchair and Walker Rentals, Inc. owns five stores in El Paso, Texas and New Mexico. Each store operates independently. Question 11: Each patient is provided a ten-page admission package that includes the warranty notice and Medicare rental policies. The appropriate sections were photographed in the report; photos of the full pages containing the requested information are attached at the end of this report. Due to technical issues during the site visit some photos could not be automatically uploaded to the report. Those photos had to be uploaded manually. The manually uploaded photos do not have the GPS, date, and time information on the photo. All photos were taken at the supplier's location at the time of the site visit. All photos were reviewed and confirmed to clearly and accurately depict the site visit details.

I prepared this document, which is the report of my inspection of the noted facility pursuant to their enrollment in the Medicare program. This report is a true and accurate account of the events that occurred and transpired on the dates described therein. I am capable and willing to testify as a witness at a hearing about the content of this report. The foregoing information is based on my personal knowledge or is information provided to me in my official capacity. I declare under penalty of perjury that this information is true and correct to the best of my knowledge and belief.

Executed This On

12/12/2023



Signature of Declarant



Printed Name

Thomas Reynolds

Date of Inspection

12/12/2023





Latitude: 31.7381649  
Longitude: -106.3261022  
Date: 12/12/2023 11:09 AM MST

#### Additional Inventory



Latitude: 31.7381649  
Longitude: -106.3261022  
Date: 12/12/2023 11:10 AM MST

#### Additional Inventory



Additional Inventory



Additional Inventory

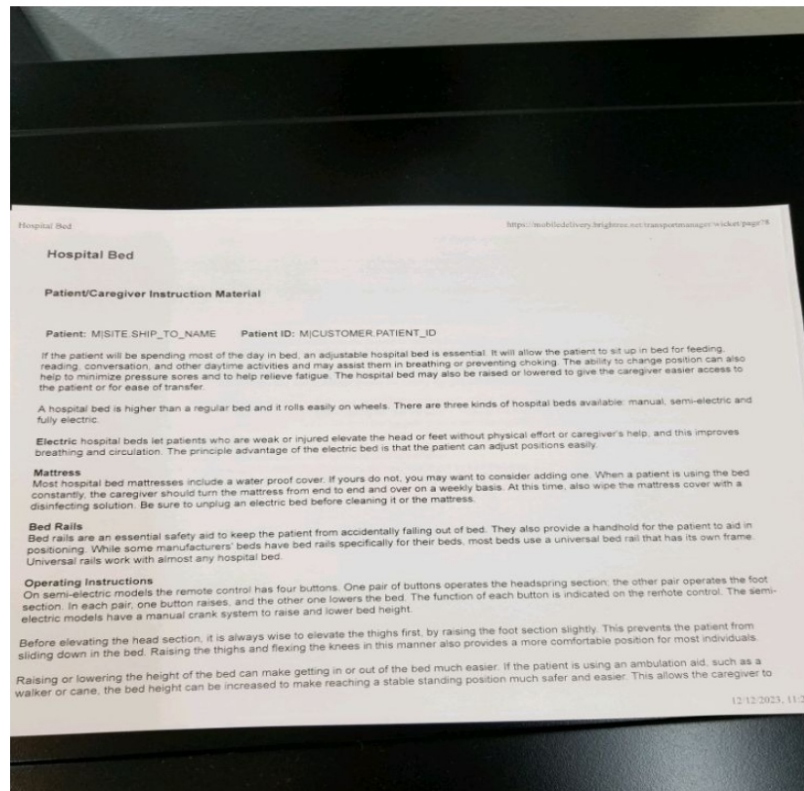


**Additional Inventory**



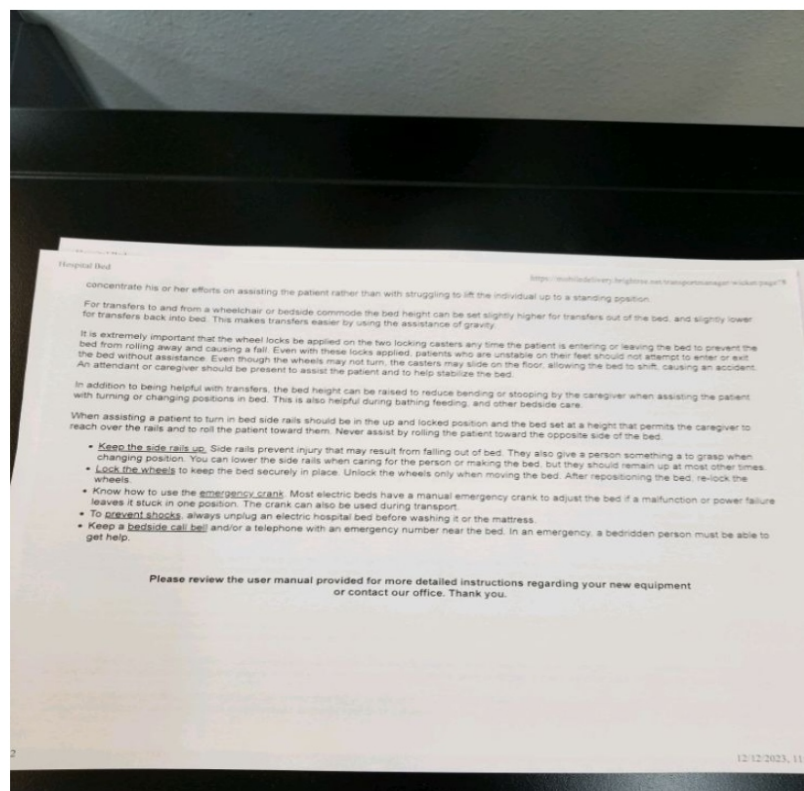
Latitude: 31.7382471  
Longitude: -106.3262145  
Date: 12/12/2023 11:05 AM MST

**Address**



Latitude: 31.7380211  
Longitude: -106.3263963  
Date: 12/12/2023 11:30 AM MST

## Patient Instructions



Latitude: 31.7380211  
Longitude: -106.3263963  
Date: 12/12/2023 11:30 AM MST

## Patient Instructions Page 2

01-300  
(Rev. 1-15/19)

## TEXAS SALES AND USE TAX PERMIT

*This permit is not transferable, and this side must be prominently displayed in your place of business.*

*Retailers: A seller may NOT accept a copy of this permit in lieu of a properly completed exemption or resale certificate. A certificate is necessary to document why tax is not collected on a sale.*

TAXPAYER NAME, BUSINESS LOCATION NAME, and PHYSICAL LOCATION

**WHEELCHAIR & WALKER RENTALS, INC.**  
**WHEELCHAIR & WALKER RENTALS, INC.**  
 1241 N LEE TREVINO DR  
 EL PASO TX 79907-1548  
 EL PASO COUNTY  
 NAICS CODE: 532490

DESCRIPTION ON NEXT LINE:  
 Other Commercial and Industrial Machinery and Equip Rental and Le  
 WE SHOW THIS BUSINESS IN THE FOLLOWING LOCAL SALES TAX AUTHORITIES:  
 COUNTY: EL PASO EFF: 05/29/2015

You must obtain a sales and use tax permit from the Comptroller of Public Accounts before you can collect sales and use tax. You must obtain a sales and use tax permit from the Comptroller of Public Accounts before you can collect sales and use tax.

*You may need to collect sales and/or use tax for other local taxing authorities depending on your type of business. For additional information, see "Collecting Local Sales and Use Tax" section on the back of this document. If you have any questions regarding sales tax, visit our website at [www.comptroller.texas.gov](http://www.comptroller.texas.gov) or call us at 1-800-392-7287.*

Glenn Hegar  
Comptroller of Public Accounts

Latitude: 31.7381649  
 Longitude: -106.3261022  
 Date: 12/12/2023 11:17 AM MST

### State Tax Permit

To: WHEELCHAIR & WALKER RENTALS, INC

Payment Date: 8/9/2022 1:44:51PM

Payment Method: Credit Card

Description: Surety Bond Renewal Effective 10/2/2022

**Medicare Bonds:**  
 Your bond is continuous and remains active until either cancelled or non-renewed. You will not receive a new bond each term. When renewal payments are made, you will be given a receipt showing that your bond is still active. We recommend printing the receipts and filing them in a safe, accessible place.

**Texas Medicaid and Florida Medicaid Bonds:**  
 Your bond will need to be renewed on an annual basis. When renewal payments are made, a continuation certificate will be issued and mailed to you. You will need to submit the continuation certificate to the Texas Medicaid and Florida Medicaid program each year. We recommend filing your continuation certificates with your bond in a safe, accessible place.

**Indiana Medicaid Bonds:**  
 Your bond is a three year term bond. We recommend printing your receipt and keeping it on file with your original bond in a safe, accessible place.

**Alabama Medicaid Bonds:**  
 Your bond will need to be renewed on an annual basis. When renewal payments are made, you will receive a confirmation receipt showing that the bond is still active. You will need to submit a copy of the receipt to the Alabama Medicaid each year. You can either fax a copy to 334-215-4298 or we recommend that you submit a copy of the receipt via certified mail to...

**HP Provider Enrollment**  
 301 Technacenter Drive  
 Montgomery, AL 36117

We recommend filing a copy of the receipt with your bond in a safe, accessible place.

| Item                                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------|
| Renewal Premium for WHEELCHAIR & WALKER RENTALS, INC, EL PASO, NPI Number: 1609989540, Effective 10/2/2022 - 10/2/2023 |

Latitude: 31.7381649  
 Longitude: -106.3261022  
 Date: 12/12/2023 11:18 AM MST

### Surety Bond

Description: Surety Bond Renewal Effective 10/2/2022

**Medicare Bonds:**  
Your bond is continuous and remains active until either cancelled or non-renewed. You will not receive a new bond each term. When renewal payments are made, you will be given a receipt showing that your bond is still active. We recommend printing the receipts and keeping your bond in a safe, accessible place.

**Texas Medicaid and Florida Medicaid Bonds:**  
Your bond will need to be renewed on an annual basis. When renewal payments are made, a continuation certificate will be issued and mailed to you. You will need to submit the certificate to the Texas Medicaid and Florida Medicaid program each year. We recommend keeping your continuation certificates with your bond in a safe, accessible place.

**Indiana Medicaid Bonds:**  
Your bond is a three year term bond. We recommend printing your receipt and keeping it with the original bond in a safe, accessible place.

**Alabama Medicaid Bonds:**  
Your bond will need to be renewed on an annual basis. When renewal payments are made, a confirmation receipt showing that the bond is still active. You will need to submit a copy of the receipt to the Alabama Medicaid each year. You can either fax a copy to 334-215-4298 or we recommend sending a copy of the receipt via certified mail to...

**HP Provider Enrollment**  
301 Technacenter Drive  
Montgomery, AL 36117

We recommend filing a copy of the receipt with your bond in a safe, accessible place.

| Item                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Renewal Premium for WHEELCHAIR & WALKER RENTALS, INC, EL PASO, NPI Number: 1609989540, Effective 10/2/2022 - 10/2/2024, Bond Number: 5047482    |
| Renewal Premium for WHEELCHAIR & WALKER RENTALS, INC, ALAMOGORDO, NPI Number: 1912073081, Effective 10/2/2022 - 10/2/2024, Bond Number: 5047483 |
| Renewal Premium for WHEELCHAIR & WALKER RENTALS, INC, LAS CRUCES, NPI Number: 1770659468, Effective 10/2/2022 - 10/2/2024, Bond Number: 5047484 |

Latitude: 31.7381649  
Longitude: -106.3261022  
Date: 12/12/2023 11:19 AM MST

## Surety Bond Page 2

Admission Packet <https://mobiledelivery.brightree.net/transportmanager/track>

**Wheelchair & Walker Rentals, Inc.**  
**Patient Admission Packet**

Patient: MSITE SHIP\_TO\_NAME Patient ID: MICUSTOMER PATIENT\_ID  
Address: MSITE SHIP\_TO\_ADDRESS/MSITE SHIP\_TO\_CITY, MSITE SHIP\_TO\_STATE MSITE SHIP\_TO\_ZIP Phone: MSITE SHIP\_TO\_PHONE\_NUMBER

**AUTHORIZATIONS:** I hereby authorize and consent to the provision of products and/or services to me by Wheelchair & Walker Rentals, Inc. I understand that I am under the control of my physician and that Wheelchair & Walker Rentals, Inc. is not liable for any act or omission when following the instructions of said physician. I authorize Wheelchair & Walker Rentals, Inc. to contact me via mail, email or phone to inform me of special programs/sales related to or a logical adjunct of the products I have received.

**PHI:** I authorize the release/disclosure of my Protected Health Information (PHI)—any records pertaining to my medical history for products or services rendered be reviewed by Wheelchair & Walker Rentals, Inc., the Centers for Medicare and Medicaid Services, my insurance carrier or other healthcare entities/providers involved in my care for purposes of determining benefits, processing a claim for payment, performance improvement, accreditation, certification, licensing or if required by federal, state or local law. Wheelchair & Walker Rentals, Inc. may disclose my PHI to family or friends involved in my care, unless I refuse in writing (See our Privacy Notice for full list of disclosures.)

**ASSIGNMENT OF BENEFITS:** I authorize direct payment of Medicare, Medicaid, insurance and any other healthcare benefits to Wheelchair & Walker Rentals, Inc. for authorized services/equipment furnished to me by Wheelchair & Walker Rentals, Inc. In the event payments for insurance benefits are made directly to me, I will endorse all checks for such payments or otherwise reimburse Wheelchair & Walker Rentals, Inc. the amount due.

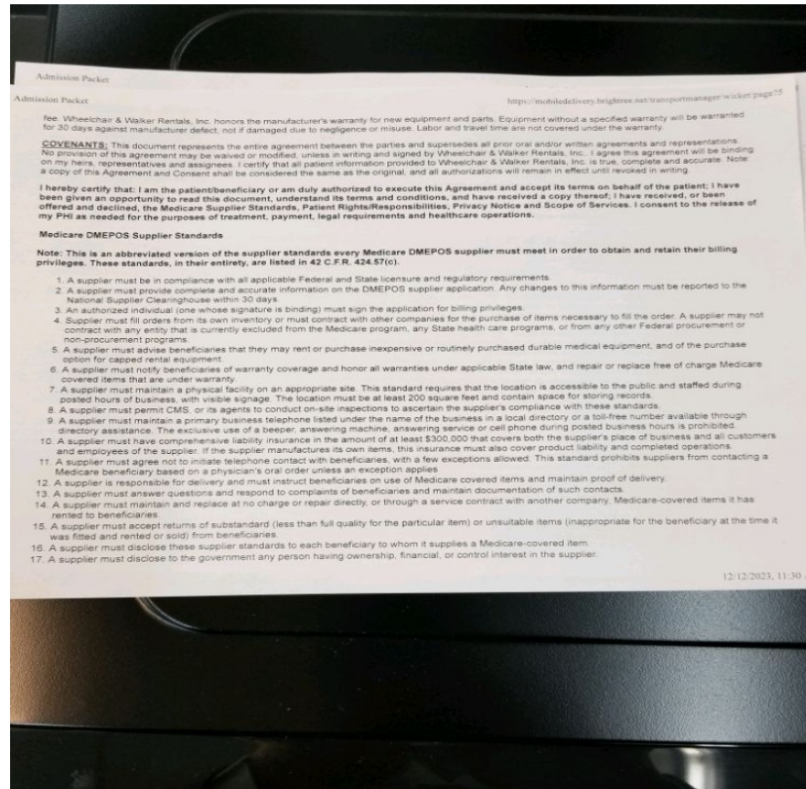
**AGREEMENT TO PAY / FINANCIAL RESPONSIBILITY:** All insurance verifications of coverage are based on plan provisions and are not a guarantee of coverage. Wheelchair & Walker Rentals, Inc. will submit your claim, but it remains your responsibility to make sure the claim is paid. We strongly recommend that you contact your insurance company to discuss your plan provisions and coverage. While insurance or other coverage may exist for the equipment provided to me by Wheelchair & Walker Rentals, Inc., I understand that not all Equipment may be covered, or that reimbursement may be less than 100% of billed charges in accordance with my coverage. Therefore, I agree to be financially responsible for any balance owed on my account including payments, coinsurance and deductibles, or even the full amount if the insurance Wheelchair & Walker Rentals, Inc. denies or recoups payment for services/equipment originally thought to be covered. I understand that if I fail to notify Wheelchair & Walker Rentals, Inc. immediately of a change in my carrier, and charges are not paid by the new carrier due to timely filing criteria, I will be financially responsible for the full amount not paid. Outstanding charges due within 15 days from date of billing statement. Unpaid accounts will be sent to collections, with collection costs charged to the patient/legal agent.

**RENTAL AGREEMENT:** I understand that if I am renting equipment from Wheelchair & Walker Rentals, Inc., the rented equipment remains the property of Wheelchair & Walker Rentals, Inc., ownership will not be transferred until all amounts due Wheelchair & Walker Rentals, Inc. are fully paid, and that the Equipment must remain within the service area unless written permission is given and documented by Wheelchair & Walker Rentals, Inc. I agree that if after reasonable effort I fail to pay any charge when due, Wheelchair & Walker Rentals, Inc. may in addition to all other remedies which may be available, peaceably repossess the Equipment without legal process. I agree not to remove or alter any identification on the equipment or in any way attempt to transfer such Equipment. Following the rental term, Wheelchair & Walker Rentals, Inc. will extend a three-day grace period for the return of monthly rentals and a one-day grace period for weekly rentals. Full rental charges will be incurred after the grace period. If you enter a hospital, nursing home or hospice care, or no longer medically need the rented equipment, you must notify Wheelchair & Walker Rentals, Inc. immediately. Medicare, Medicaid and most insurance plans do not cover medical equipment while you are in the hospital, nursing home or under hospice care.

**RETURN/WARRANTY POLICY:** Returns are accepted only within 14 days of purchase with the original receipt, in the original, unopened and undamaged packaging. Products are NOT RETURNABLE if modified, used, custom-made, for personal care or worn against the body. Returns are subject to a 20% restocking fee.

Latitude: 31.7380273  
Longitude: -106.3263954  
Date: 12/12/2023 11:36 AM MST

## Warranty Information



Latitude: 31.7380273  
Longitude: -106.3263954  
Date: 12/12/2023 11:36 AM MST

## Warranty Information Page 2