A TOPIC AOPA IS WORKING ON THAT IS IMPORTANT TO THE FUTURE OF YOUR BUSINESS

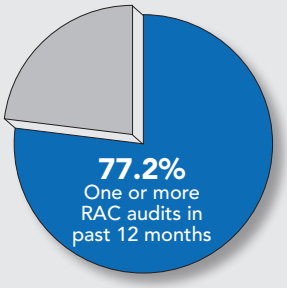
RAC Audits and the Craziness Confronting O&P

There is one issue that rises above all others in threatening the O&P community as never before. Just months ago, perfectly legitimate Medicare claims that were paid without jeopardizing patient care and provider's ability to deliver that care have suddenly been viewed as likely fraud and abuse candidates. What happened and what's AOPA doing about it?

The Core of the Issue

Two things happened. First, Congress passed the Affordable Care Act (ACA) and no matter which side of the political spectrum you may fall on, it affected O&P and other medical services in a similar manner. Somehow, CMS has to find $700 billion to pay for ACA's expanded benefits. One way is to curb fraud and abuse. The second event is the August 2011 HHS Office of Inspector General's Report that threw a misguided spotlight on O&P. The report, among other things, claimed that Medicare reimbursements for lower limb prosthetics climbed 27 percent while the number of beneficiaries declined about 2.5 percent. Because lower limb prosthetics are a big ticket item, the gun sights were trained on O&P claims. Never mind that over the five year comparison fee updates accounted for more than 12 percent of the increased expense. Never mind that improved prosthetic technology delivers more benefits in mobility and that it costs more money. Never mind that the OIG report was flat out wrong in inferring fraud simply because there was no recent office visit of the patient with the referring physician, as well as in alleging fraud from whether claims for multiple prosthetic limbs for bilateral amputees appeared on one form or on multiple claims forms. And of course never mind that the true incidence of actual fraud and abuse in O&P is negligible.

Why Is It Important To You?



The question of why it is important to you hardly needs asking—anything that interferes with timely payment of legitimate services provided your patients is a huge threat. The survey AOPA conducted recently on RAC audits and related issues drew more than 200 responses. 77.2 percent of those responding said they had experienced one or more RAC audits in the past twelve months and 53.9 percent said they had gone through at least one audit in the past three months. One hundred and one or about 50 percent of the respondents said they had undergone 3 or more audits and sixty-six said they had experienced 6 or more audits in the past twelve months. These numbers clearly spell epidemic.

More than 100 members provided eye-opening comments that alternately made you ill or raging mad. The common thread was "my patients are at risk; my business is at risk; and the future of O&P is at risk."

What Is AOPA Doing About This?

This issue is our highest priority. It's front and center above all else. A full summary of all actions, including access to specific documents which far exceed the space available here, is available at *www.AOPAnet.org/PhysicianDocumentationBackground.pdf*. But, here are just a few examples of what we've done so far.

STEP ONE. AOPA immediately wrote the DME MAC Medical Directors challenging their interpretation on physician documentation., including the assertion that prosthetists' observations and notes were no longer appropriate as part of the patient's physician record AND we also requested intervention and a meeting with Dr. Peter Budetti, head of the CMS fraud and program integrity section.

STEP TWO. AOPA joined with the O&P Alliance in a letter to then CMS Administrator, Don Berwick and to Daniel Levinson, the HHS Inspector General pointing out specific errors in the report and also requesting a meeting and prompt intervention.

(Continued on page 2)

(Continued from page 1)

STEP THREE. AOPA brought the matter to the attention of Senator Ben Cardin (D-MD) resulting in a letter to the newly appointed CMS Administrator, Marilyn Tavenner. Sen. Cardin questioned the new policy and expressed concerns over its impact on delivery of timely care to Medicare amputee beneficiaries.

STEP FOUR. The requested meeting with Dr. Budetti occurred and he agreed that physician visits were generally not the patient's point of contact if a prosthesis needed repair or the patient needed a replacement for a like device. AOPA, again with the O&P Alliance, met with the CMS officials responsible for Medicare audit contractors and secured a commitment to correct one DME MAC error, namely the prosthetist's notes, once entered in the physician's file, DO constitute a legitimate part of the patient's medical record.

STEP FIVE. In the O&P Alliance meeting with the HHS Office of Inspector General, OIG defended their report but also expressed surprise at both the instantaneous reaction of the DME MAC contractors, as well as the ways in which it had prompted a change in the standard of care in prosthetics mandating physician visits where there had never been mandatory visits before and in the face of no statutory requirement for a physician visit—again CMS has reversed fields in (1) a recent newsletter stating that a same kind of replacement prosthesis requires neither a physicians visit or order, and (2) stating in the recent physician fee schedule rule that at present, there is no requirement for a face-to-face physician visit to obtain a prosthesis or orthosis.

The new CMS Administrator, Marilyn Tavenner, raised the issue in a meeting with O&P officials stating that a "middle ground" needs to be found. AOPA has brought the message to Capitol Hill by cooperating in providing sample claims rejections and other information to a Senate Finance Committee team tracking the over-aggressiveness of Medicare auditors. We've generated a very pointed "Medicare Says Don't Walk" advertising blitz in the Washington, D.C. market. We have even investigated whether auditors' unfair retrospective attempts to use documentation criteria first articulated within the past 12 months as a standard for rejecting claims from 3 or 4 years ago—and the resulting retroactive rejections may offer a litigation option to halt these audit excesses.

These and several other actions, including the observation by one high ranking CMS official urging AOPA members to appeal all the way up to the Administrative Law Judge level where a win on legitimate claims is a very strong possibility, have yielded some encouraging signs that CMS gets it and they are addressing the problem. But, it's clear that even the CMS Administrator, who must resolve it, has to navigate through a maze of issues involving contractors, the OIG, internal disagreements on a solution and the usual roadblocks inherent in any governmental bureaucracy. It's slow in coming and the only thing that can hasten action is for you, our members, to join the battle AOPA has been fighting for the past year on behalf of you and your patients by barraging your elected representatives with compelling examples about how patient care is being severely compromised. Perhaps, only then, will we start seeing action. This is not a time to "Let George Do It."

All AOPA members have received a link to the survey summary and I urge each of you to read the comments members submitted. If you missed receiving the link, go to *info@aopanet.org* and request the RAC Audit Survey Summary. It should be sufficient inspiration to write that letter which ideally should be faxed to your Senator or Congressman.

The Bottom Line

We've been doing our very best. So far even our best has not been enough to turn the tide, but we are not yielding an inch—we'll continue the fight with all our creativity and resources until fairness is restored.

Very truly yours,

Thomas F. Fise, JD
AOPA Executive Director