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

Physician Documentation: Ramp Up Changes On How O&P Care is Delivered

The Core of the Issue

Changes in how patient care is delivered in any aspect of health care is a big deal. In an age when people talk a lot about "evidence-based" practice, we like to think that changes in the delivery of care should occur in order to reflect new science or to improve the patient's experience or outcome. Over a hundred years ago, anesthesia became the norm in surgery because it reduced pain for the patient. Twenty years ago, laparoscopic surgery took root because of shorter patient recovery times. Even in simple things, one of the Medicare 'pay-for-performance' benchmarks has focused on frequency of hand-washing to reduce prospects of disease transmitted from one patient to another.

In the past six-plus months, we have seen a radical change in how patient care is delivered in orthotics and prosthetics, and it has not been one iota about new science or improvements to patient experience. It has been solely about money. The recent obsessive-compulsion pre-occupation by HHS/Medicare and its contractors on an exponential ramp-up of physician documentation requirements in order for providers to be paid has changed the face of O&P patient care. Someone's naïve thoughts about how to stop payments to bad, fraudulent actors has mutated into large scale, unjustified denial/reversal of claims for payments to reputable providers for bona fide care they have rendered, and a huge impediment for your limb loss (and limb-impaired) patients.

This meltdown started in August, 2010 with the HHS Office of Inspector General publishing its report, "Questionable Billing Practices in Lower Limb Prosthetics." By looking at claims files, and relying primarily on internal CMS medical staff for guidance, OIG made some questionable findings, including:

1. *They did not observe the typical medical pattern where a patient visit with a physician precedes the prescription of therapeutic steps or commencing costly treatment steps. Instead of physicians acting as 'gate-keepers' controlling referrals for specialty care, they identified many patients whose physicians had ordered replacement prostheses, even though Medicare had no records of the patient seeing the physician over the past five year*
2. *They saw what they perceived as confusing coding of claims for bi-lateral amputees—some with a single claim for both limbs, while others had separate claims unique to each limb. What was common and accepted billing practice on these patients was perceived by OIG as suspicious and potentially fraudulent.*

It was a symptom of today's world replete with too many contractors operating with the powers or, and in the stead of government, that DME MACs and government audit contractors—the latter being referred to by some as 'bounty hunters' because they get paid on the basis of how many claims they can deny or reverse—leapt into action, even before the ink was dry on the report (and before CMS officials were even aware of the OIG report).

Claims that had been clear, accurate and paid in July were rejected in September as having inadequate physician documentation. DME MAC Medical Directors issued "Dear Physician" letters, telling doctors in no uncertain terms that they had to beef up the details in their patient orders for prosthetic care. By November, one Medicare contractor was reporting "services determined to be billed in error…resulting in an overall Charge Denial Rate of 86.6%. And 96% of the denied claims were missing the physicians' clinical documentation to corroborate the prosthetist's records and support medical necessity." Physicians were not exactly trembling as they read the "Dear Physician" letter—they care for their patient, but didn't have much of a dog in the fight as their reimbursements were unaffected. And of course CMS didn't offer any additional payment for the time it would take to beef up documentation. The payment for their patient visits was unchanged, regardless of the 'quality' of their notes and clinical documentation. What did change dramatically was the patient's experience—there was no safe harbor for prosthetists to be sure of being paid, and of necessity, patients were sent back to their physicians multiple

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times for more and more documentation. We saw a letter from one physician practice to a litany of suppliers including those of "mobility devices" that stated, "This is to inform you that beginning immediately we will trash all forms regarding any of the above items…We suggest sending your forms to the patients to bring with them to the appointment." In a very significant number of patients, the result has been a substantial delay in securing access to the O&P devices they need for the restoration and maintenance of their mobility.

Isn't this enough? Today, a patient can call on their physician with a complaint about pain and walk out with a small prescription, signed by the physician for Oxycodone—a drug monitored by the DEA. By contrast, in O&P the physician will typically write and sign a short note on a sheet from that same prescription pad, referring the patient to an O&P facility for a prosthesis. Once the patient has been examined, the doctor will receive, review and sign a detailed work order usually prepared by the prosthetist. These two independent exhibits of physician documentation, his/her intent that the patient needs a prosthesis of this type, is now frequently deemed by the bounty hunters not to be enough. Documentation by the prosthetist is deemed self-serving and therefore does not support "medical necessity." Claims have been denied because the physician's notes don't include a statement—patient is an amputee (despite a written, signed order requesting an artificial limb). Or rejected because the physician's signature is deemed not to show legibly all of the letters in his/her name.

Why Is It Important To You?

The obvious answer is that if you aren't paid, or have to return a payment for a prosthesis you have already delivered to a Medicare patient, you are on the line for a lot of money. Reports are that O&P providers have had reasonably good success when they have chosen to appeal rejected claims and gone before an administrative law judge. But that too costs money and precious time. No one can afford to do that for every claim.

What Is AOPA Doing About This?

Immediately following the release of the OIG report, AOPA, partly in conjunction with the unified efforts of the O&P Alliance, and in part on its own, challenged the decision in four venues: AOPA joined with the O&P Alliance in letters to the Administrator of CMS and to the Inspector General of OIG, challenging the report. AOPA independently requested a meeting with Dr. Peter Budetti, the head of the CMS Program Integrity Office, and wrote to the DME MAC Medical Directors questioning those portions of their "Dear Physician" letter which indicated that documentation generated by the prosthetist was not recognized as proof of "medical necessity" because of the inherent conflict as a person paid to deliver care.

No action was taken by the CMS Administrator. The DME MAC Medical Directors responded, in essence claiming that all AOPA objections to their letter to physicians were without merit. In a separate meeting, some of CMS' full-time, internal Medical Directors disagreed, saying that when a prosthetist's observations, notes and recommendations are placed by the physician in the patient file, they become, without anything more, part of the physician's documentation and records.

AOPA and other O&P leaders did meet with Dr. Budetti and his staff. While they did not discount the assertions of AOPA/O&P attendees, neither have they taken any action to resolve the problems.

Partners in the O&P Alliance, including myself, met recently with OIG representatives. They did not acknowledge that any of the complaints and observations we made constituted deficiencies in their report, though they did seem surprised both with the extent of the audit contractors' instantaneous response and the disruption of patient care delivery that it has precipitated.

AOPA initiated communications with counterpart staff of the American Medical Association, which has generally been empathetic with the problems this CMS/OIG/contractor action has caused. AMA is encountering a very broad-based push from CMS to force greater physician documentation across the board, well beyond O&P. Unfortunately, our members and their patients appear to have been innocently caught in the throes of this much larger fight.

AOPA has been communicating on the topic of these physician documentation requirements and gauging the potential adverse impact on patients with: (1) the Amputee Coalition; and (2) several Congressional offices who have an interest in this issue.

So that AOPA members are equipped to address some of the allegations of potential fraud in the OIG report, whether via press inquiries or patient requests, we have prepared and made available to all AOPA members a series of talking points on this topic.

We are by no means satisfied with where this problem sits. While we wanted to underscore the problem and relate to you what has been and is now being done, we also want to reassure our members that this is a very TOP priority for us moving forward, and we will continue every conceivable effort to bring this problem to a fair, clear and expeditious solution.

Very truly yours,

Thomas F. Fise, JD
AOPA Executive Director