American Orthotic & Prosthetic Association

Overview of O&P RAC Audit/Pre-payment Audit Problem

Background

Actions of the Medicare Contractors Is So Severely Constricting Cash Flow in Small O&P Businesses (Annual Total Sales Roughly $1 Million) As Major Force Prompting Closings of these businesses and trigger fewer choices/providers to patients and a significant consolidation in field

1. HHS OIG generated a report which was premised on very significant misunderstanding of the patient care delivery model, and recommended inaccurate and unrealistic actions.
2. CMS accepted most of the major findings of the OIG report without correction or rebuttal.
3. That said, CMS' Office of Program Integrity has determined that whatever is going on with O&P care and documentation, there is generally an absence of indicators of fraud (contrary to the premise of the OIG report)
4. Medicare contractors exacerbated the problem by 'announcing' new standards without reference to the APA and without the benefit of any rulemaking
5. Audit contractors have applied the newly announced standards retrospectively as to claims where the provider could have not knowledge of the standard at the time services rendered.
6. OIG's gross misunderstandings of the care model, faulty conclusions drawn fro those inaccuracies, and contractor false assumptions of fraud have triggered a second wave of massive pre-payment audits designed to stimulate diminution in the applicable standard of amputee care. These pre-payment audits (in Jurisdiction B approaching 100% of prosthetic claims) have made the cash-flow problems for small O&P businesses dramatically worse.
7. O&P practitioners and patients have become Medicare's surrogates and collateral damage because neither has the leverage to compel physicians to provide the greater documentation that CMS demands and physicians are unwilling to give.
8. CMS contractors appear to operate without rules, supervision or coordination.
9. When CMS contractors do secure substantial caches of additional physician documentation it is misused as rat:ionale for detached audit personnel who have never seen the amputee patient, generally without either credentials or experience in orthotics or prosthetics, to countermand the prescription and care orders of the physician who has the responsibility for the overall clinical care of the patient.

(Over Please)

Recommendation

Communicate your concerns as a Member of Congress: (1) by signing onto the joint, bipartisan Congressional letter to Secretary Sebelius and CMS Administrator Tavenner; and/or (2) by communicating directly in a letter to CMS Administrator Tavenner and follow-up discussions with top CMS staff, that patients with limb loss or limb impairment may be getting shortchanged in the type of device they receive or experience delayed treatment when overzealous CMS contract auditors cite misunderstood documentation errors as basis for claim denials. The audits are designed to uncover fraud and abuse and not to foster "gotcha" denials adversely affecting patient care.

DRAFT Letter

Dear Administrator Tavenner,

I am writing to express my concerns about significant changes made to documentation requirements for the coverage of prostheses in the Medicare program. These policy changes stem from the August 2011 Department of Health and Human Services Office of the Inspector General report, "Questionable Billing by Suppliers of Lower Limb Prostheses" (OE1-02-00170). These changes are adversely impacting the ability of the supplier community to provide the appropropriate prosthetic limbs to Medicare beneficiaries.

A direct result of this report has been a significant increase for physician documentation which is often difficult to obtain. One DME audit contractor recently reported a lower limb prostheses claim denial rate of 86.6 percent with 96 percent of these denials attributed to insufficient physician documentation. The supplier community believes that many of these claims denials are erroneous and the physician documentation is adequate and identical to documentation submitted prior to the OIG report. They maintain that the only thing that has changed is CMS contractors having announced without any rulemaking a new, excessive and unattainable requirements for documents from physicians.

Suppliers must rely on physicians to comply with these additional documentation requirements, but they are facing increased physician frustration over these additional requirements and, in many instances, physicians are refusing to comply with these requirements. The increase in claims being denied because of physician documentation issues adversely affects the ability of suppliers to provide prostheses and ultimately this can compromise the quality of care afforded to Medicare beneficiaries.

While I support efforts to ensure that only appropriate claims are paid and to investigate all instances of fraud and abuse, I am concerned that the emphasis CMS and its contractors are placing on additional physician documentation could hinder access to care. I request that you take steps to work with the supplier community to ensure that these program integrity efforts go through the right rulemaking channels and do not impede the providing these vital services to Medicare beneficiaries.

For more information contact the American Orthotic & Prosthetic

Association (AOPA) at (571) 431-0876 or www.AOPAnet.org