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

The Department of Justice (DOJ) Responds to AOPA's Lawsuit Against CMS Seeking Dismissal of Our Complaint—A Critical Round One

The Core of the Issue

AOPA's lawsuit against CMS for promulgating a change in policy without proper procedures which resulted in the ruinous RAC audits has entered a crucial stage. As we have noted many times, suing CMS or the government in general is always an uphill battle—the government has huge resources and it is hard to beat them. Yet, as everyone knows, filing the lawsuit was the only recourse after exhausting every other possible remedy. The DOJ motion to dismiss our complaint was expected. It's usually always the first step by government in their own defense. The judge might choose to dismiss our complaint. But, if the judge elects to not grant dismissal, it is a very positive and encouraging development. AOPA has until August 6th to respond and we will make a very vigorous argument that the suit should continue.

Why Is It Important To You?

It's important that AOPA takes every possible step to protect our members and their patients in this increasingly difficult healthcare climate. This lawsuit is a critical piece in calling a government agency to account for actions that have seriously undermined O&P patient care and the ability of many O&P providers to remain in business. Even the government is not entitled to do whatever they want, however they want, whenever they want. There is a process they are expected to follow. CMS through its contractors will always have to conduct audits to make sure Medicare payments are proper and that fraudulent claims are not paid with taxpayer dollars. But, if there is going to be a change in the rules, then proper notice must be given and an opportunity must exist for all stakeholders to voice their views so that any final rule or policy has the benefit of informed judgment as well as fair warning.

You must be provided a new rulebook if the rules change and be given an opportunity to make necessary adjustments to comply with new rules going forward. Changing the rules and then applying the new rules retroactively just isn't right and that's a big part of why AOPA has pursued this action so aggressively. It's our job to make sure things are right to the best of our ability and to provide you with whatever guidance we can to make sure you and other members can make necessary adjustments for compliance.

What Is AOPA Doing About This?

Since filing the lawsuit AOPA has gathered information about how patients and members have been affected by delayed service, claw backs of previous reimbursements, and yes, even identifying companies that have been unable to weather the storm and have gone out of business. These and other facts will help support AOPA efforts to keep the lawsuit alive so the judge has an opportunity to review all the facts in coming to a determination.

As of press time for this newsletter, AOPA has pursued another very interesting development that still poses some mystery. All of us will doubtless agree that there has been little, if any, good news on RAC and related audits on O&P over the past 23 months. But something quite remarkable has happened in the past couple of weeks, something that we attribute to the filing of AOPA's lawsuit. One of the major claims AOPA has made in our suit is that the CMS audit contractors have inappropriately applied the new standard articulated in the August 2011 Dear Physician Letter retroactively to claims in 2009 or 2010, well before anyone had any reason to think the standard had changed. Over the past two weeks, we have heard from a fair number of AOPA O&P provider members that the CMS RAC contractors had notified them that audits of claims with dates of service before August, 2011—the very claims that were contested by one of the AOPA suit's most vociferous assertions—have been cancelled. Just this past week, AOPA has gotten word from two separate members in different states that audit contractors explained these cancellations by saying that they had received a notification from CMS instructing that any O&P prosthetic audits relating to claims with a service date before August, 2011, be cancelled. CMS has said nothing to explain this action, but they seem to have recognized that they did make an important change in the standard via the August, 2011 Dear Physician letter AND that it is unfair and inappropriate (if not illegal) to apply that new standard retroactively.

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This is not the first time CMS has initiated major changes in policy of RACs as a result of a lawsuit being filed. Earlier this year, the American Hospital Association (AHA) sued CMS relating to what AHA deemed to be inappropriate and confiscatory actions by CMS audit contractors. Shortly after the lawsuit was filed, CMS announced a new interim rule whereby if audits determined that a Medicare patient should not have been admitted as an in-patient under Part A to receive a service/surgery/procedure, Medicare (instead of its old policy which had been, by RAC audit, to claw back every dollar of the claim paid on behalf of that Medicare beneficiary) would allow the hospital to re-file a claim under Part B for the amount Medicare would have paid for that patient on a claim submitted had the service/surgery/procedure been received on an outpatient basis. So far, this has not resulted in any change in the lawsuit itself. It is possible that the government decided it would be easier to defend its position in that lawsuit if it adopted prospectively a more reasonable position.

So what's happening in O&P and how will it affect you? One explanation is that CMS realized that audit activity on claims paid with pre-August 2011 service dates were indeed improperly audited. Then the question is how about the pre-August 2011 paid claims where reimbursements were clawed back? Does this rescission possibly suggest monies clawed back by Medicare can be refunded? Does this rescission activity suggest someone at CMS realizes that AOPA's lawsuit claiming retroactive claim denials pre-August 2011 were indeed improper?

We must caution AOPA members not to infer from this that there is any probability or certainty that CMS will adopt a consistent and rational policy, namely, there is **no indication or assurance whatsoever** that CMS/Medicare will return the dollar amounts its auditors have already collected retroactively as to prosthetic O&P claims where the date of service was before August, 2011. That would make sense to all of us, but as we know, Medicare very often does not act logically. We hope that this might be the eventual result of either Medicare attempting to treat O&P prosthetic providers more fairly or as a result of the ongoing litigation. But at this point there is no way, and no information at our disposal to speculate about what the government might do.

The Bottom Line:

The RAC audits egregious damage visited on many O&P providers are just one example of why AOPA and its members must be ever vigilant in monitoring CMS activities in all areas. There's certainly no suggestion that the RAC audits and other activities or changes undertaken by CMS have any ulterior motives. Officials and employees at CMS are trying to do their job in guarding against fraud and abuse and few people at CMS are familiar with O&P and the vital services we provide to patients. The bulk of CMS audit activity in O&P seems focused on trying to drive down the K level, presumably on the false assumption that K-levels are somehow being "upcoded." In fact, the data from Medicare records in a study funded by AOPA, commissioned by the Amputee Coalition and conducted by the highly regarded health care consulting firm of Dobson DaVanzo actually contradicts the assumption of upcoding. The study showed the actual total Medicare costs of K3/K4 level patients are lower than the total Medicare costs for K1/K2 level patients (despite the fact that a K3/K4 prosthesis alone is more expensive than a K1/K2 prosthesis).

So we have to be on guard at all times watching closely to make sure well intentioned efforts in the quest of finding the $700 billion to pay for the Affordable Care Act, partly by curbing fraud and abuse, doesn't inadvertently claim O&P providers and patients as victims. AOPA will continue to do its best to prevent that from happening.

Sincerely,

Thomas F. Fise, JD
AOPA Executive Director