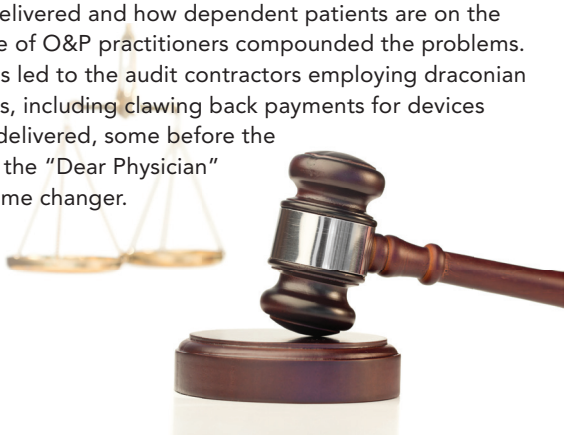
A TOPIC AOPA IS WORKING ON THAT IS IMPORTANT TO THE FUTURE OF YOUR BUSINESS

When All Else Failed—There Was No Choice But to Litigate — AOPA Made That Tough Choice So There Is a Chance That O&P Patient Care and Your Business Can Continue!

The Core of the Issue

On May 13th AOPA filed a 25 page complaint in U. S. District Court for the District of Columbia outlining the egregious actions pursued by CMS contractors since August of 2011 that have decimated O&P patient care and the businesses of many AOPA member providers. CMS actions were initially triggered by a flawed Office of Inspector General Report inferring that a 30% + increase in Medicare spending for lower limb prostheses during the 2005-2009 periods while the number of beneficiaries dropped from 76,000 to 74,000 or by 2.7% indicated inappropriate payments by CMS of $43 million. A "Dear Physician Letter" from the CMS Region Medical Directors responded to the OIG Report unleashing the CMS contractors down a "crash and burn" audit track creating havoc in O&P patient care and the cash flow disruption and subsequent demise of many fine O&P businesses. In this rapid-fire response to the OIG Report, CMS through its contractors failed to follow well established rules for "notice and comment"— rules which assure stakeholder input on new/revised government standards and policies. The resulting audits applied the new standard for physician documentation/medical necessity retroactively to claims for services years before the new standard was announced.

The OIG report failed to recognize the upward Medicare "fee schedule" increases after years of no increases that occurred during that period or the fact that the wars in Iraq and Afghanistan placed new emphasis on developing higher technology prosthetic and orthotic devices which naturally resulted in higher costs. Further misunderstandings of how care is delivered and how dependent patients are on the expertise of O&P practitioners compounded the problems. All of this led to the audit contractors employing draconian measures, including clawing back payments for devices already delivered, some before the onset of the "Dear Physician" letter game changer.



Why Is It Important To You?

RAC and pre-payment audits have posed the gravest threat to the viability of O&P practices (and therefore their suppliers) in a generation. This lawsuit seeks redress by requesting the Court to enter a judgment and decree that would invalidate the physician documentation standards in the "Dear Physician" letter because among other things it was not promulgated as a regulation through formal rulemaking in compliance with the Medicare Act and the Administrative Procedure Act which require notice and comment opportunities by interested parties. Among other things, it would also order Secretary Sebelius to reopen and reprocess all claims submitted by AOPA members that were denied based on alleged failure to meet the documentation requirements set forth in the "Dear Physician" letter and compel the Secretary to issue regulations within 60 days regarding the qualifications of suppliers of orthotics and prosthetics as required by Section 427 of BIPA which was enacted in 2000 and never implemented by CMS.

What Is AOPA Doing About This?

The March 2013 Executive Director letter outlined the tedious task of laying the groundwork to sue CMS for changing the rules without following proper rulemaking practices. AOPA's legal counsel on this matter, Winston and Strawn, wrote Secretary Sebelius and Administrator Tavenner two separate letters of December 15, 2012 and April 15, 2013 recounting the efforts AOPA had made to convince CMS to return to a fair and equitable process that would relieve the unfair burden on O&P patient care and the precarious plight of O&P providers whose cash flow has been devastated, in some cases to the threat of bankruptcy by these audits. Countless meetings with the Administrator and top officials at CMS met with little success. Examples of egregious claims denials found little understanding. Since March, AOPA and legal counsel gathered more and more information and examples of patient harm and provider

(Continued on page 2)

(Continued from page 1)
disruption and translated it into one hundred and ten separate counts of failed or improper actions by CMS and resulted in the eleven separate requests for entering a judgment and decree in favor of AOPA members and seeking an award of AOPA costs and attorney's fees.

Despite the fact that suing the government is an uphill battle and possible costs approaching a half a million dollars, it gives voice to the statement made in the March Executive Director Letter, "We're mad as hell, and we're not going to take it any more."

In the most recent meeting, on May 8, CMS Administrator Tavenner promised that CMS is: (a) working on a physician template, which she says might even be completed by the prosthetist, and signed off on by the physician. A legitimate question is, if it were implemented perfectly by CMS, how this would be different than where we started in July, 2011 before the OIG report and "Dear Physician" letter; Administrator Tavenner also promised that CMS would issue before the end of 2013, two new proposed rules: (b) a rule requiring pre-authorization, opining that pre-authorization would essentially eliminate the need for RAC audits (but pre-payment audits based on medical necessity/physician documentation are a problem comparable in magnitude to RAC audits). CMS can't seem to understand DME is very different from O&P and that that medical necessity for artificial limbs is very different from power mobility equipment—it is pretty evident that if a person is an amputee, the need for an artificial limb is pretty obviously a medical necessity; and (c) a rule implementing BIPA Section 427 accreditation and certification provisions.

Those solutions almost certainly miss the mark in large measure and just as importantly, the timing falls far short….missing the point of how these audit procedures today are literally putting O&P practices out-of-business. On May 7, CMS released on its website a 4-page list of components for a physician template – it is incompatible with the Administrator's promise that it would be capable of being completed by the prosthetist and is of such great specificity, very few physicians would provide such extensive detail.

It really came down to a keen understanding that no other options exist in trying to defend AOPA members from this insidious intrusion into patient care and the filing of a lawsuit was truly our only recourse.

The Bottom Line:

You'll be receiving separate communications about the need for the O&P community to come together and pool its resources in contemplation of a future that in all likelihood may include future needs to litigate for survival. It's a sad commentary, but realistically, a necessary truth to acknowledge and be prepared to undertake. If you want more background or want to read the complaint against CMS you can go to AOPA's home page *www.AOPAnet.org* and click on the CMS lawsuit icon right in the middle of the page. You can also see how you can support this effort. Thanks to every AOPA member for their loyal support that provided the initial financial wherewithal to undertake this effort. We've tried to husband your resources to make this possible but at the same time we must recognize that this may only be the first step in a longer journey of survival.

Sincerely,

Thomas F. Fise, JD
AOPA Executive Director