



**American Orthotic &
Prosthetic Association**

STUDY: MEDICARE AUDIT “MESS” SURGING AT RATE OF 15,000 NEW APPEALS PER WEEK, AGENCY COULD AVOID RAPIDLY MOUNTING INTEREST PAYMENTS

AOPA: More than 100 Small Health Care Providers Already Shut Down Due to Delays and Many More at Risk; No End in Sight to Estimated Backlog of 1.5 Million Appeals Now Languishing.

WASHINGTON, D.C.//March 19, 2015//With a massive backlog of Medicare reimbursement appeals by health care providers growing at the alarming rate of 15,000 a week and with handling of the appeals delayed from the 90 days required by law to three years or longer, the Centers for Medicare & Medicaid Services (CMS) could save \$12 million over a decade by postponing reimbursement of disputed payments until the disputes are resolved, according to a new analysis from Dobson DaVanzo & Associates (Dobson DaVanzo) commissioned by the American Orthotic and Prosthetic Association (AOPA). The report is available online at www.aopanet.org.

AOPA said that a major side-benefit of such a step would be to relieve the often unbearable financial strain on small health care providers – such as orthotic and prosthetic firms – that are unable to deal with being bombarded by the uncertainty resulting from long-delayed Recovery Audit Contractor (RAC) appeals for disputed Medicare payments. More than 100 small health care businesses already have been forced to close their doors by the pressure from the appeals backlog and many more are in danger of being shuttered, according to the Association.

AOPA noted that the 15,000 new appeals received per week means that there are as many as 1.5 million Medicare reimbursement cases now in limbo ... and with no additional resources available to resolve them in a timely way.

Charles Dankmeyer, president, American Orthotic & Prosthetic Association, said: **“The truth is that there is a real and growing mess today at Medicare when it comes to Recovery Audit Contractor appeals that are stacking up in the system and with no relief in sight. Legitimate Medicare audits are a necessary part of the federal government discharging its responsibility to protect federal moneys and to fight fraud and abuse. However, the current RAC system has flaws, starting with the fact that RAC auditors are incentivized to maximize their assertions of provider errors in order to collect a ‘bounty’ of up to 13 percent for every dollar clawed back. The result has been an out-of-control surge in audits and a worsening situation for small health care providers – including orthotic and prosthetic providers – that are unable to survive the cash flow nightmares in what is a hostile environment, as they wait years for their day in court where odds say they’ll likely win, but sometime too late to keep their businesses afloat.”**

Study co-author Audrey El-Gamil, senior manager, Dobson DaVanzo, said: **“Our study found that the appeals system at the Administrative Law Judge (ALJ) level is broken. As a result, there are two main consequences. First, the government currently pays out almost one-third of its total recouped funds for improper Medicare payments in the form of interest payments to successful provider appeals. The delay in the review process - about 30 months – significantly increases the amount of these interest payments. Second, providers have their money withheld by the government for the duration of the review, which leads to financial uncertainty. A policy change could mitigate the cost to the government and reduce the financial uncertainty faced by providers.”**

Mary Palmer, business manager, Nelson Prosthetic and Orthotic Laboratory, a Buffalo, New York firm, said: **“The company I work for has been in business for 30 years. We had 14 full-time employees and had to let go two people because of the unbearable strain and uncertainty associated with these audits. Nelson now has tremendous difficulty planning, knowing that these audits can hit at any time and that the appeals can last indefinitely. Within first month of the new RAC program in January 2012, Nelson was hit with 28 audits. It was a crisis for the company. Nelson was able to battle these down to six official audits, but it took several months of our time to get it there. Four of these audits are now in appeal, and have been there since 2012, which means Nelson has had to pay out all the money up front. The total value on these outstanding appeals is \$44,000, including a single service of \$23,000 for a prosthetic leg. That may not sound like a lot in Washington, but it’s a heavy weight for a small business to bear.”**

As the Dobson DaVanzo analysis explains, the Office of Medicare Hearings and Appeals (OMHA) within the Department of Health and Human Services (HHS) handles the four levels of appeals for Medicare claims and entitlement issues. The third level (Level 3) is a hearing with an Administrative Law Judge. A common Level 3 appeal heard is Recovery Audit Contractor (RAC) appeals. In these instances, RACs attempt to retrospectively collect allegedly improper overpayments made from Medicare to providers. In order for a RAC claim to enter a Level 3 appeal (ALJ hearing), the provider must first reimburse CMS for the payments in dispute. If the ALJ hearing rules in the provider's favor (fully or partially favorable disposition), CMS becomes responsible for reimbursing the provider for the submitted payment plus interest at above market rates for the time period between provider repayment and the ALJ determination.

But the system is not working as intended. According to statute, the ALJ has up to 90 days to review each appeal and issue its decision from the date of appeal request. However, due to a significant increase in RAC and other types of audits, OMHA estimates that based on current volume and workload, assignment of requests for hearings could be delayed for up to 28 months, with an additional six-month delay after assignment of the appeal. In July, 2013 OMHA stopped assigning new claims to ALJs for hearings, meaning that the delays, nearly three years then, are getting much longer as new claims sit, awaiting processing and assignment. Because interest is determined by CMS based on the interest paid on the number of months that CMS has access to the provider's payment, the backlog of ALJ appeals represents a significant and growing expense to CMS for successful appeals.

Testimony from Nancy Griswold, Chief Administrative Law Judge, estimates that in July 2013, OMHA's Central Operations Division received over 15,000 claims per week.

AOPA is formulating a legislative policy that would change the timeline for when provider payment for claims under review would need to be submitted. Specifically, the recoupment date for RAC audits would be delayed until after the ALJ hearing and determination. Under this policy, CMS would not be holding providers' payments while the ALJ hearing is in process, therefore, CMS is not accruing interest to be paid to providers with favorable (or partially favorable) determinations.

The focus of Dobson DaVanzo analysis is on orthotic and prosthetic (O&P) RAC audits that reach Level 3 appeals, the analysis also considers the Medicare savings if all Part B services were included in the policy. On average, O&P appeals in 2013 represented an average Medicare payment of \$35,338. Based on OMHA data, closed appeals for O&P services have a success rate of 51.9 percent; therefore, CMS would no longer be holding the providers' money for months or years as the appeals were pending, and would save money by no longer needing to accrue and pay interest for about half of all appeals.

Under this proposed policy, CMS would not recoup payments from providers for possible overpayments until the ALJ disposition is determined. This would eliminate the need for CMS to make interest payments, estimated to be \$7.57 million for O&P services over ten years or \$12.37 million for all of Part B services in the appeal system (including those yet to be recognized by OMHA). Furthermore, providers with successful appeals would not have their resources withheld by CMS for upwards of 30 months before they received their repayments, according to the Dobson DaVanzo analysis.

ABOUT AOPA

The American Orthotic & Prosthetic Association is a national trade association committed to providing high quality, unprecedented business services and products to O&P professionals. Since our founding in 1917, we have worked diligently to establish ourselves as the voice for O&P businesses. Through government relations efforts, AOPA works to raise awareness of the profession and impact policies that affect the future of the O&P industry. AOPA membership consists of more than 2,000 O&P patient care facilities and suppliers that manufacture, distribute, design, fabricate, fit, and supervise the use of orthoses (orthopedic braces) and prostheses (artificial limbs). Membership in AOPA represents a professional milestone; it is recognition of leadership and achievement in the O&P community.

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EDITOR'S NOTE: A streaming audio recording of the news event will be available on the Web as of 5 p.m. EDT on March 19, 2015 at www.aopanet.org.