American Orthotic & Prosthetic Association

CMS Audits—RACs, Pre-Payments, CERTs: Where Are We, How Did We Get Here, and What Can Practitioners Do and Expect Moving Toward the "New Normal?"

Dear AOPA Member,

AOPA Members are aware that on May 13, 2013 AOPA filed suit against HHS in the Federal District Court for the District of Columbia. Our complaint seeks relief from the unfair and unauthorized actions of the Center for Medicare and Medicaid Services, primarily via actions of its RAC auditors and DME MACs relating to physician documentation requirements.

AOPA's suit does not (and cannot) seek to eliminate Medicare's right to audit claims. Rather, the AOPA suit insists that Medicare must act fairly in those audits and it specifically asserts that CMS and its contractors have not followed the required process in making changes to the medical necessity/physician documentation requirements which were invoked in August, 2011 as the new 'standard' for prosthetic claims.

Background Facts—How Did We Get to This Point?

While we did not know it 26 months ago, August 2011 was a benchmark month for the vitality of the O&P profession, and for the quality of care that we provide to our patients. During that month, the HHS Office of Inspector General released a flawed, and in some respects amateurish, report alleging fraud in the O&P field where there essentially was none. The report: (1) misunderstood that patients don't go to their physician when their prosthesis is not working properly; (2) misunderstood that it is not unusual that most Medicare amputees may not see the 'referring physician' who first prescribed their prosthetic care because that physician is commonly the surgeon who amputated their limb; (3) created extensive confusion about whether bi-lateral amputees should have both prostheses on a single claim or two separate claims; (4) leapt to conclusions of fraud because claims costs had increased with a fixed number of Medicare amputee beneficiaries while failing to recognize that Iraq-Afghanistan had prompted a quantum leap in technology (and a related incremental increase in unit cost) which together with CMS-approved O&P fee schedule increases (after years of 'freeze') had indeed driven per capita increases; and (5) failed to track as required by BIPA 427 whether or not care providers were, or were not, qualified providers under federal law. But the worst thing this flawed OIG report did was trigger an adverse change in the quality of patient care for Medicare beneficiaries through a change in the requirements for reimbursement.

Someone at Medicare should have known better. CMS leadership or its DME MAC contractors should have pointed out the flaws in this OIG report and pushed back. But no one did. Contractors dramatically and unilaterally revised the standards by which a prosthetic claim would be judged simply by publishing the "Dear Physician" letter. AOPA believes that in doing so Medicare violated the law, specifically the federal Administrative Procedure Act and the Medicare Act.

The Medicare Administrative Contractors and Recovery Auditors then launched a full-frontal audit assault on the O&P profession. Less than one year after the Office of Inspector General's report, a survey demonstrated that more than 75% of all prosthetic companies were defending Medicare audits. Prepayment claims reviews were also initiated, scrutinizing claims after the prosthetist has delivered a device to the patient, but before Medicare

has reimbursed it. Both audits and prepayment claims reviews, therefore, create enormous liquidity issues for prosthetic facilities, most of which are small businesses without ready access to capital.

AOPA, along with many others, including all of our partners in the O&P Alliance and the majority of our member firms, have fought at every turn over the past 26 months to try to explain and persuade CMS that its actions on this matter are unfair, contrary to the statutes and detrimental to the care provided to Medicare beneficiaries. A chronology of many of the actions AOPA has taken is available for your review.

Faced with crippling cash flow issues, many prosthetists have responded to the audits and claims reviews by moving away from the products that Medicare has focused on—components for medium activity-level patients—and toward devices generally applicable for low activity level amputees. While this has the short-term effect of insulating them from the negative effects of audits and payment delays, it exposes them to long-term ramifications that are significant and largely negative. Product trade downs and putting lower-end components on patients who need higher-activity ones will result in poor patient satisfaction and outcomes as well as, providing only limited relief until CMS redirects its attention to this lower category of devices and services.

The OIG/CMS action has changed the standard of care, often forcing practitioners to choose between meeting the patient's immediate need for a prosthesis by providing a less sophisticated device, rather than endure long delays in care triggered by the paper chase with physicians. The truth is that CMS wants physicians to provide more documentation, but isn't willing to pay them anymore, and physicians have pushed back by refusing to provide more documentation for prosthetic care.

So what's happened with the lawsuit? The government had 60 days to file its answer to AOPA's claim. On July 19, the Department of Justice responded by filing a Motion to Dismiss the suit. This was expected—the government asserted that AOPA doesn't have the right to bring this lawsuit, and that the Federal District Court doesn't have the authority to hear the suit. Congress didn't want just 'anyone' to be able to challenge the Medicare program, so they set some tight rules that preclude many lawsuits. For example, most notably, you cannot sue Medicare to contest the amount it pays. Most lawsuits against Medicare fail, and most of those failures occur because the Court grants the government's Motion to Dismiss. August 6 was the deadline for AOPA's attorneys to respond to the government's Motion to Dismiss and we requested that the judge hear oral arguments on the Motion to Dismiss. We have solid confidence that when the Court ultimately rules on the Motion to Dismiss, it will rule in our favor. But it will likely take 6-8 weeks (or longer) before we know.

What Happens If AOPA Wins? What Happens If AOPA Loses?

In the interim until the case is decided, many O&P Medicare claims will be filed for payment, and audits will occur. Those practitioners who treat the "Dear Physician" letter as if it were legitimate, and have all possible back-up documentation, including physician records to support the claims and the K-level have the best chance to succeed in the interim.

If AOPA wins the lawsuit, Medicare might ultimately remedy its problems by going through the right process to establish a new standard, but this will take time, and would only apply prospectively to claims filed **after** the new standard was adopted, and not retroactively as CMS contractors have tried to do with the "Dear Physician" standard.

And if AOPA ultimately loses, things would remain at status quo. CMS contractors could be expected to enforce the "Dear Physician" standard through future audits.

What Are Take-Away Prudent Messages—What Can Practitioners Do, and Expect, Moving Toward the "New Normal?"

As inappropriate as we believe Medicare's actions have been, there are also lessons to be learned by the O&P professional from this extremely difficult experience. Inasmuch as we may disagree with the types of audits performed, the volume of claims audited, or the audit outcomes we've experienced, one thing remains true—

lawsuit or no lawsuit: CMS and its Medicare contractors have a right and a duty to review or audit the claims it pays.

Because of the volume of claims that Medicare contractors process, it is not possible to screen every single claim to the level of detail that we see during an audit; most claims are paid so long as they can pass through the automatic screens that CMS has in place. Historically this relatively low level of claim screening or oversight has caused some suppliers (and some of our peers) to develop a laissez-faire (or worse) attitude toward claim submission and documentation. At the same time as the bar for claim documentation has been raised, the quality of submitted claims and supporting documentation has suffered. Thus, Medicare has increased its success rates in recouping payments.

The noise we're hearing from providers of O&P services is related to the pain being felt by individual entities and their own experiences within the current audit processes; however, ***the pain is not the same for all providers within a given DME MAC jurisdiction.*** Because we are part of a payment system that pays any DMEPOS supplier number for custom prosthetics, we must remember that CMS is seeing a much higher failure rate among other types of DMEPOS providers compared to qualified providers, thereby reinforcing their motivation to pursue the audits.

Even within our profession, not all of the providers experience the same audit results. The differentiator is the ability of the O&P supplier to furnish proper claim documentation. Another fallacy is that we presume all O&P suppliers are as professional as we ourselves are. We are therefore impacted by all the noise from those practices' (perhaps certified and accredited) who have demonstrated an inability or unwillingness to develop the types of documentation and claim submission safeguards others may have had in place for years.

With claim error rates regularly above 70%, auditors and claim reviewers have no reason not to expand into the lower-activity claims. We may see more and more activity move into the final level of Medicare appeals: The Administrative Law Judge. Many of the prosthetic claims denied in late 2011 and 2012 are just now finding their way to these judges for a final hearing. This trend will likely continue even though the anecdotal evidence suggests an extraordinarily high prosthetic facility win rate of greater than 80%. Preparing your claims to be appealed all the way to the ALJ level takes patience and perseverance, but this is a necessary persistence to stay in business.

For example, review the results of the recent DME MAC A: K3 Claims Prepayment Review announcement.

http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/030813_llp.pdf

There are a couple of important points to remember in reviewing this rather self-serving March 8 announcement from DME MAC A.

Specifically, in this notice DME MAC A mentions:

Additional Documentation Request (ADR) were not received for 19 (13%) of the claims.

- The billing supplier did not reply to the DME MAC's request for information at all. There is little option for Medicare other than to deny these claims.

Proof of delivery - 12% of the denied claims were missing the proof of delivery.

- Lack of proof of delivery is clearly a fatal flaw and is not a new or changed requirement. These claims also should be denied.

There should be no claim overlap in the 12% & 13% error rates stated above; thus far 25% of the claims failed on the most basic of Medicare claim requirements and should be denied.

Lack of Medical Record Documentation - 30% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

- This error rate may be suspect and self-serving as physician documentation is rarely presented at initial claim submission; rather, it is asked for in 2nd and 3rd level reviews. If it is asked for in first level review it is sometimes difficult to get and cannot be acquired within the response time allotted.

Evaluation/assessment documentation - 4% of the denied claims were missing the evaluation/assessment documentation for the functional level of item(s) billed (prosthetist assessment).

- This could be a proper number; at any rate every prosthetist should have a strong process in place for reasons that go beyond Medicare claim payment.

Clinical documentation did not support the functional level of the Lower Limb Prosthesis - 32% of the denied claims had clinical records that did not justify the functional level of the billed item.

- It probably makes sense to interpret this to mean the prosthetist's documentation, rather than the physician's; every prosthetist should have a strong K-level assessment process, and accompanying documentation, in place.

There is likely overlap within the three categories immediately above. However, outside of the problem of physician documentation, these issues are under the control of the prosthetist, and represent good clinical practices. None of us should be ignoring these important clinical documentation elements.

Going forward, caution is the watchword. The more we push the more likely we will have a wholesale revision of the present processes. The present state is the "new normal" of claims validation and cannot just go away. It is also performing the very important function of editing out the unqualified prosthetic suppliers who may presently be in the system. The qualified supplier with good document controls will survive the transient pain of this initial process into the new normal, which will continue to serve as a barrier to entry for the unqualified.

Beware that requests for a prior approval process or CMS mandated forms would be a huge step backwards. Most importantly, these proposals would immediately demote us from clinical professionals to DME vendors in the eyes of all payors.

Sincerely,

Thomas F. Kirk
AOPA President
On Behalf Your Officers and Directors

Thomas F. Fise
Executive Director

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