



**American Orthotic &
Prosthetic Association**

Support the Medicare Orthotic & Prosthetic Improvements Act

113th Congress In the House – H.R.3112

**Enhanced Enforcement, Qualifications Linked to Complexity of Device and
Limiting Deemed Accrediting Bodies Would Decrease Fraud & Abuse, Improve
the Quality of O&P Care and Generate Savings to Medicare**

Background

Recognizing the wide range of skills necessary to provide quality orthotic and prosthetic care, Congress passed Section 427 of the BIPA in 2000, Section 302 of the Medicare Modernization Act (MMA), and CMS issued Transmittal 656.

BIPA Section 427: Mandated regulations within one year of enactment to limit payment for custom fabricated orthotics and all prosthetics to only those provided by “qualified practitioners” (defining which professionals could provide O&P care to Medicare beneficiaries) and “qualified suppliers” (linking supplier qualifications to two O&P accrediting organizations or others deemed “essentially equivalent” by the Secretary). These regulations were never issued and this provision was never implemented.

MMA Section 302: Created a requirement for all DMEPOS suppliers to become accredited in order to bill Medicare, regardless of whether the supplier participates in DME competitive bidding. CMS granted deemed status to 11 accrediting organizations (every organization that applied) to accredit O&P suppliers, some with no experience with the O&P field or any track record with accreditation generally. CMS also developed weak, very general quality standards for O&P suppliers. There is serious concern that this will result in far more suppliers having explicit federal approval to provide comprehensive and complex O&P care who are simply not qualified to do so, the opposite of the intent of the statute.

Transmittal 656: Effective October 1, 2005, CMS issued Transmittal 656, which required Medicare to only pay for O&P claims from practitioners and suppliers that meet the requirements of state O&P licensure laws. This Transmittal applied to the nine states that had O&P licensure in 2005, including Florida, Texas, and Illinois. There are now 15 states with O&P licensure laws. At the time of passage of the BIPA legislation, only a handful of states had these laws in place. Medicare claims data analysis of the 4th quarter of 2005 strongly suggests, and CMS has subsequently acknowledged, that this Transmittal has not been implemented. What is required is for CMS’s contractors, the DME MACs (which administer DMEPOS claims) to program payment edits into their

computer systems by state, so that Medicare will not pay for O&P care that is provided by suppliers who do not meet each of the 15 states' O&P licensure laws.

Proposal No. 1: Enhanced Enforcement

Congress should mandate that CMS adopt and fully implement within 90 days the content of Transmittal 656 for all states with O&P licensure laws (now and in the future) to assure that Medicare payments for O&P services and devices are made only to qualified O&P practitioners and suppliers. Within 180 days, CMS should take the next logical step to fully implementing Section 427 of the BIPA law, which requires Medicare to only pay qualified practitioners and qualified suppliers for custom fabricated orthotics and all prosthetics in every state. *[Cost Implications: Since both of these provisions are not currently implemented, mandating CMS to do so would clearly be a saver, whether CMS recognizes these savings or not. Since only a few states had licensure at the time that BIPA was enacted, there is a strong argument that implementing these provisions would generate additional savings.]*

The American Orthotic and Prosthetic Association (AOPA) commissioned Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) to analyze Medicare claims data from 2007 through 2011 to determine the extent to which Medicare is reimbursing non-certified O&P personnel in states with a licensure statute for selected O&P services. The analyses conducted by Dobson | DaVanzo was then compared to prior analyses of claims data conducted on behalf of AOPA from 2001 through 2006. The findings and trends of the data analyses from 2007 to 2011 were compared to the trends from 2001 to 2006.

The data from 2001 to 2006, and from 2007 to 2011, show that there has not been any significant change by CMS to eliminate payments to unlicensed providers in O&P licensure states. Specifically, no reduction in the proportion of payments to non-certified O&P personnel has been evidenced since 2009. In fact, the data show an increase in the proportion of Medicare payments to non-certified personnel in licensure states. Our analytic results are consistent with the results of a third party independent survey that confirmed that non-certified providers are continuing to provide O&P services to Medicare beneficiaries as recently as in 2013. If any CMS enforcement to eliminate payments to unlicensed providers in O&P licensure states has occurred, it does not appear to have to been effective.

Proposal No. 2: CMS Should Establish a Link Between Provider Qualifications and the Complexity of O&P Care Provided

The statute contemplates a division consistent with assigning four categories of O&P products, ranging from off-the-shelf to custom fabricated, but CMS has never established a regulation that links payment with both device complexity and provider qualifications. The services/equipment in O&P become increasingly more complex as you move across the spectrum from off-the-shelf in the direction of custom fabricated, and require greater qualifications for providers. Implementing a modification for eligibility to access Medicare payment that would specifically link payment, device complexity and provider qualifications would assure better outcomes for patients, and create savings by eliminating payment to under-qualified persons (often duplicative payments if the beneficiary ultimately requires corrective modifications or a new device) who currently receive Medicare payment.

Congress should adopt the framework of a revised payment system in O&P that would explicitly link practitioner and supplier qualifications with the level of complexity of the

orthotic and prosthetic care being provided to the patient. These levels of complexity would be consistent with, but more specific than, the existing statutory language (i.e., off-the-shelf, pre-fabricated (low skill), pre-fabricated (high skill), custom fabricated), thereby improving quality and reducing claims from unqualified suppliers and potentially generating savings. Guidance on what devices correspond to each of these categories is already provided in existing statutory and regulatory documentation.

Proposal No. 3: Reduce the Number of Deemed Accrediting Bodies in Orthotics & Prosthetics

Congress initiated a process allowing CMS to identify and authorize select accrediting bodies in O&P with the objective of tightening enforcement and eliminating bad actors/unqualified providers (BIPA Section 427). The standard established was that any deemed accrediting body would need to observe requirements “essentially equivalent” to either the American Board of Certification in Orthotics and Prosthetics (ABC), or the Board of Certification/Accreditation (BOC). MMA Section 302 created a requirement for all DMEPOS suppliers to be accredited. Unfortunately, instead of adhering to the requirements of BIPA Section 427 and being selective by choosing a few well-established O&P accrediting entities that have a track record and high standards, CMS threw the process open to new and inexperienced entities with minimal standards and without any assurance that they employ staff with knowledge about O&P. This makes it easier for unqualified providers to “shop” for certification to a deficient standard, giving unqualified providers a “credential” directly contrary to Congress’ objective.

Recommendation

Congress should instruct CMS to: (1) implement the regulation under Section 427 of BIPA 2000, which has been awaited for fourteen years; and (2) limit its recognition to those certifying bodies which in fact meet the legislative quality criteria already established in BIPA 427, and to rescind the certifications of any bodies currently recognized, that do not measure up to that legislative quality standard. Assuring that providers must meet the stricter qualifications of one of these established certifying bodies will meet the original Congressional intent of narrowing Medicare providers to those who are truly qualified, and thereby generate savings by eliminating payments to unqualified providers, who are likely to be the perpetrators of fraud and abuse.

These recommendations were also echoed by the Department of Health & Human Services Office of Inspector General in its October 2012 report, [CMS Has Not Promulgated Regulations To Establish Payment Requirements For Prosthetics and Custom Fabricated Orthotics.](#)

Savings

Morrison Informatics has **estimated savings of between \$86 to \$216 million each year from enactment; the bill in past versions has included a guarantee of a minimum of \$250 million of savings over five years** if the Medicare O&P Improvements Act becomes law. Assertions by some that Medicare no longer pays unlicensed and unaccredited providers are untrue, as demonstrated by the work of Dobson-DaVanzo noted above. Enacting H.R. 3112 would: (1) save Medicare money by only paying providers who meet legal requirements; (2) help patients achieve quality care; and (3) not be opposed by other care providers.

For more information contact the American Orthotic & Prosthetic Association (AOPA) at (571) 431-0876 or www.AOPAnet.org.