American Orthotic & Prosthetic Association

Endorse Congress' Initial Determination That Orthotics & Prosthetics Needs to be Exempted from Any Post Acute Care Bundling

Background

Congress is considering several options for the elimination of the sustainable growth rate (SGR) formula which consistently triggers significant legally-mandated reductions in the Medicare physician fee schedule, or a permanent "doc fix". If a permanent "doc fix" is implemented, Congress will need to identify at least $130 billion of new Medicare cuts to offset or pay for the elimination of the current SGR formula.

One proposal to offset the "doc fix" that is gaining traction is the implementation of a post acute care bundling model—whereby Medicare would make a single (reduced) payment to one contracted entity, e.g., a rehab hospital, which would then sub-contract in a "low bid" type process, to provide all services for each individual patient for the first 90 days after discharge from the hospital.

Prosthetics and orthotics (artificial limbs and orthopedic braces) are very different from durable medical equipment (DME) inasmuch as it is not the distribution of commodities; rather orthotic and prosthetic care involves an ongoing series of clinical services provided by licensed and/or certified professionals resulting, through the use of devices, in the ability to regain or maintain ambulation and full function.

Under the present Medicare structure, beneficiaries with limb-loss or limb-impairment are permitted to choose the licensed and/or certified health care professional with whom they establish a patient care relationship. Importantly, as limb-loss is a permanent condition, this relationship is generally established for the patient's entire life. The patient has the right to choose a provider with whom they are comfortable and who best addresses their mobility needs. This clearly is a relationship that needs to be based on more than just a lowest-bid contractual relationship.

Congress has already provided clear indication, by virtue of how it excluded most O&P services and items from the competitive bidding program, that this patient choice and the provider relationship needs to be protected. In 2003 Congress exempted/limited competitive bidding to only "off-the-shelf orthotics," which were defined as devices which could be used by the patient with "minimal self-adjustment" and which do not require any expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

Similarly, bundled payments are poorly suited for the delivery of custom O&P care because the devices and related clinical services are of a unique nature that is not appropriately captured by a system that relies on a comparison between what may seem to be similar or substitute items and services.

In the initial legislative draft, Congress correctly chose to exclude orthotics and prosthetics (along with physician services and physical therapy) from post acute care bundling. That was the right decision. To include O&P in bundling would be a radical change to the Medicare system, and catastrophic for these limb-impaired individuals if adoption of post acute care bundling interrupted those existing patient care relationships or denied Medicare beneficiaries the right to choose their prosthetist/orthotist.

Recommendation

We believe that Post Acute Care bundling, as it is being presented now, would best serve beneficiaries by continuing to exempt O&P care from the bundled payment and preserving the licensed and/or certified prosthetist/orthotist relationship in the same way you are protecting the patient/beneficiary's right to select his/her physician, physical/occupational/speech therapist. That would be the safest route to protect these limb-loss/limb-impaired Medicare beneficiaries.

For more information contact the American Orthotic & Prosthetic

Association (AOPA) at (571) 431-0876 or www.AOPAnet.org

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Post Acute Care Bundling: Sample Exemption Language

Option A: Proposed and Preferred Statutory Language:

‘‘(B) EXCEPTIONS.—Such term does not include—
“(i) physicians’ services;
‘‘(ii) hospice care;
‘‘(iii) outpatient hospital services;
‘‘(iv) ambulance services;
‘‘(v) outpatient physical therapy services; and
“(vi) “prosthetics and orthotics” as defined by Section 1861 (s)(9)

Option B: Less preferable because it is more intrusive to patients, to follow the pathway Congress set in competitive bidding:

‘‘(B) EXCEPTIONS.—Such term does not include—
“(i) physicians’ services;
‘‘(ii) hospice care;
‘‘(iii) outpatient hospital services;
‘‘(iv) ambulance services;
‘‘(v) outpatient physical therapy services; and
“(vi) prosthetic and orthotic devices and services, with the exception of those off-the-shelf orthotic devices if
(a) CMS has included such devices in an actively operating competitive bidding program under section 1861(s)(9);
(b) A list of such off-the-shelf orthotic devices has been published pursuant to final notice and comment rulemaking under 5 U.S.C. § 500 et seq.; and
(c) In developing the list of such devices, the Secretary uses a strict definition and criteria of off-the-shelf devices established in Section 1847 (a)(2), consistent with section 1834(h). “

(Section 1847 (a)(2) defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Social Security Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.)

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