



**American Orthotic &
Prosthetic Association**

Overview of O&P RAC Audit/Pre-payment Audit Problem

Background

Actions of the Medicare Contractors Is So Severely Constricting Cash Flow in Small O&P Businesses (Annual Total Sales Roughly \$1 Million) As Major Force Prompting Closings of These Businesses and Trigger Fewer Choices/Providers to Patients and a Significant Consolidation in Field

1. HHS OIG generated a report which was premised on very significant misunderstanding of the patient care delivery model, and recommended inaccurate and unrealistic actions.
2. CMS accepted most of the major findings of the OIG report without correction or rebuttal.
3. That said, CMS' Office of Program Integrity has determined that whatever is going on with O&P care and documentation, there is generally an absence of indicators of fraud (contrary to the premise of the OIG report)
4. Medicare contractors exacerbated the problem by 'announcing' new standards without reference to the APA and without the benefit of any rulemaking
5. Audit contractors have applied the newly announced standards retrospectively as to claims where the provider could have no knowledge of the standard at the time services rendered.
6. OIG's gross misunderstandings of the care model, faulty conclusions drawn from those inaccuracies, and contractor false assumptions of fraud have triggered a second wave of massive pre-payment audits designed to stimulate diminution in the applicable standard of amputee care. These pre-payment audits (in Jurisdiction B approaching 100% of prosthetic claims) have made the cash-flow problems for small O&P businesses dramatically worse.
7. O&P practitioners and patients have become Medicare's surrogates and collateral damage because neither has the leverage to compel physicians to provide the greater documentation that CMS demands and physicians are unwilling to give.
8. CMS contractors appear to operate without rules, supervision or coordination.
9. When CMS contractors do secure substantial caches of additional physician documentation it is misused as rationale for detached audit personnel who have never seen the amputee patient, generally without either credentials or experience in orthotics or prosthetics, to countermand the prescription and care orders of the physician who has the responsibility for the overall clinical care of the patient.

(Over Please)

10. In April, 2013, 35 House Members signed on to a Joint Letter to Secretary Sebelius, seeking fixes to the RAC problem. When the Secretary replied over three months later, in July, she offered no substantive changes or actions to resolve the problem, and those actions she promised have not been implemented yet, another nine months later.
11. In April 2013, CMS Administrator Tavenner promised to issue before 12/31/13 proposed regulations to implement Section 427 of BIPA 2000 so as to define qualified providers, and thus clarify the legitimacy of the prosthetist's notes/records. No such proposed regulations have been released by CMS, a full 12 months later.

Recommendation

Communicate your concerns as a Member of Congress: (1) by signing onto the joint, bipartisan Congressional letter to Secretary Sebelius and CMS Administrator Tavenner relating to excessive delays to reach ALJ hearings (2) join in support of Part B – RAC Audit legislation; and/or (3) by communicating directly in a letter to CMS Administrator Tavenner and follow-up discussions with top CMS staff, that patients with limb loss or limb impairment may be getting shortchanged in the type of device they receive or experience delayed treatment when overzealous CMS contract auditors cite misunderstood documentation errors as basis for claim denials. The audits are designed to uncover fraud and abuse and not to foster “gotcha” denials adversely affecting patient care.

For more information contact the American Orthotic & Prosthetic

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