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Ensuring Beneficiary Access to Orthotics and Prosthetics Act of 2014
Summary Section-by-Section Analysis

Purpose: To amend the Medicare law to recognize orthotic and prosthetic (O&P) suppliers as independent professional providers of medical care for Medicare beneficiaries, to improve the Medicare administrative appeals process, and for other purposes.

Section 1: The title of this legislation is the "**Ensuring Beneficiary Access to Orthotics and Prosthetics Act of 2014**."

Section 2: *Medical Record*: This section re-establishes that the clinical notes of the treating orthotic or prosthetic practitioner are considered part of the patient's medical record and are relevant for the medical necessity determination of orthotic and prosthetic (O&P) care.

Section 3: *Weight of Clinical Documentation:* This section clarifies that the clinical records of the treating orthotic or prosthetic practitioner have equal weight to the records of other allied healthcare professionals treating the patient.

Section 4: *Separation of O&P from DME*: This section seeks to distinguish durable medical equipment (DME) suppliers from orthotic and prosthetic practitioners by creating a new section in the statute for orthotists and prosthetists that mirrors DME supplier requirements with minor changes.

> *Patient Access to Off-the-Shelf Orthotics*: Section (d) of this section addresses the only O&P care that is subject to competitive acquisition under the Medicare program. This subsection would permit appropriately credentialed orthotists and prosthetists to provide "off-the-shelf" orthotics to Medicare patients in the course of treating the patient's overall O&P needs, similar to how physicians are able to under existing law.

Section 5: *Rebilling of Appropriate Codes*: This section of the bill explicitly allows O&P practices to rebill for the remainder of the claim if only one or more (but not all) Healthcare Common Procedure Coding System (HCPCS) codes are denied, with the entire claim being deemed an overpayment as a result.

Section 6: *[This section (and Sec. 7, 8, and 9) applies to ALL Medicare beneficiaries and providers]*

> **Section 6(a)**: *Forego Reconsideration*: Allows Medicare beneficiaries, providers, and suppliers to skip the second level of appeal, the "reconsideration" stage, after the first-level redetermination has been made, and appeal directly to an Administrative Law Judge (ALJ).

Section 6(b): *Default Judgment for Stale Decisions*: Establishes a default judgment in favor of the provider or supplier if a decision of the ALJ is not rendered in compliance with the statutory requirement that all ALJ decisions be rendered within 90 days from the ALJ request for hearing.

Section 6(c): *RAC Funding of ALJs*: Permits funds recovered through the RAC program to also help fund the hiring of additional ALJs.

Section 7: *Technical Denials*: This section clarifies that the medical record as a whole must be considered when CMS and its contractors determine the medical necessity of an item or service for purposes of payment. It protects against technical documentation errors leading to claims denials by prohibiting such minor errors from being the sole grounds for a claim denial.

Section 8: *Reopening Old Claims*: This section requires CMS to show good cause to reopen old claims that have been long-since paid and settled. It also reaffirms jurisdiction to hear provider challenges to violations of the good cause standard by administrative law judges and in the federal courts.

Section 9: *Stay Recoupment*: This section permits a provider or supplier to stay recoupment until an ALJ decision is rendered.

Section 10: *RAC Transparency and Financial Penalty*: This section addresses the transparency of RACs by requiring CMS to publish RAC audit rates and appeals outcomes at each level of review. It also establishes reporting requirements for separate categories of providers (i.e., a category for O&P providers that is separate from DME providers). This section also penalizes RACs by imposing a financial penalty of half of their contingency fee if 25% or more of their recoupments in each category are overturned on appeal.

Section 11: *O&P RAC Audit Pause*: This section requires all Medicare contractors to "pause" their denials of O&P claims provided by appropriately credentialed providers based on medical necessity until such time as the OMHA Chief Judge determines that OMHA is meeting its statutory time deadlines of deciding Medicare cases within 90 days of receiving a request for an ALJ hearing.

Section 12: *Effective Date*: This section establishes the effective date of this Act as the date of enactment.

Section 13: *Regulations*: This section requires the HHS Secretary to issue regulations to implement this Act within 120 days of enactment.

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