American Orthotic & Prosthetic Association

Statement of the American Orthotic and Prosthetic Association on Short Stays and Unintended Consequences of RAC Audits and the Massive Backlog of Medicare Appeals on May 20, 2014 Before the Health Subcommittee of the House Ways and Means Committee

The American Orthotic and Prosthetic Association (AOPA) is pleased to provide this statement concerning Medicare fraud and the delivery of care to Medicare beneficiaries who have suffered a loss of a limb or impaired use of a limb or the spine. AOPA, founded in 1917, is the largest orthotic and prosthetic (O&P) trade association, with a national membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss or limb impairment. Members include patient care facilities, manufacturers and distributors of prostheses, orthoses, and related products, and educational and research institutions. The field of providing artificial limbs or customized bracing for those Medicare beneficiaries with limb loss or limb impairment is a highly specialized area representing a small, roughly one-third of 1 percent, slice of Medicare spending but has a huge impact on restoring mobility to those patients served. A replacement limb may mean the difference between returning to work and a former life quality and remaining an active and contributing member of society. Customized orthotic bracing solutions for chronic conditions may have a similar long range impact.

That is why AOPA was pleased that this hearing announcement referenced orthotics and prosthetics by noting, "Importantly, short stays are not the only area of concern when addressing RAC audits, appeals and an increase in observations stays. For example there are a number of durable medical equipment and prosthetic/orthotic cases that are also held up at the ALJ appeal level."

AOPA submitted a statement for this Subcommittee's hearing on April 30, 2014 on ideas to improve Medicare oversight to reduce waste, fraud and abuse in which we outlined suggestions that would assist in this endeavor. We respectfully request that our statement of April 30, 2014 also be incorporated by reference, together with this statement, into the record of this hearing.

In that earlier statement, AOPA referenced the effect RAC audits are having on delivering timely patient care, the disruption of service brought on by these audits, and the lack of due process in the heavily-backlogged appeals process. Our members were stunned when the Office of Medicare Hearings and Appeals announced a suspension in the scheduling of hearings before Administrative Law Judges, which has been the only remaining recourse our members have to fight unfair audit claim denials.

AOPA still believes that the best and surest way to combat fraud in the orthotics and prosthetics sector is to prevent fraud in the first place. There are constructive ways to fight fraud without punishing an entire healthcare sector, such as hospitals and orthotic and prosthetic (O&P) providers.

H.R. 3112 Is a Positive Step in Fighting Fraud; Surety Bonds Are Not an Answer to Fraud—They Punish All Legitimate Medicare Providers, Without Posing Any Significant Barrier to Unscrupulous Actors Who Perpetrate Medicare Fraud

Effectively fighting Medicare fraud requires implementing truly effective measures aimed at stopping unscrupulous actors and saving Medicare dollars. CMS's imposition of surety bond requirements on all providers has been misdirected because it has little relationship to preventing fraud. These bonds burden all

O&P suppliers, disproportionately affecting small O&P suppliers, but they do nothing to distinguish legitimate suppliers from fraudulent suppliers. Surety bond requirements are ineffective at preventing Medicare fraud and unnecessarily penalize legitimate providers.

Legislative Efforts Relating to Limiting the In-Office Ancillary Care Exception to Stark Self-Referral Rules

AOPA has noted that W&M Ranking Minority Member, Rep. McDermott has introduced a bill aimed at eliminating the exception from the Stark self-referral provisions for in-office ancillary services. AOPA supports this new legislation in principle. The Orthotic & Prosthetic Alliance in recent months has communicated concerns to OIG about how, in the context of physician-owned distributorships (PODs), the in-office ancillary services rule sometimes operates and results in an increase in the number and value of services that patients do not need. However, no substantive action was taken. This provision has also prompted state legislative issues in states like Texas where it has been used by special interests to try to expand the prospects for payments to unqualified or under-qualified providers.

Prior Authorization is Not an Answer for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The topic of prior authorization in terms of Medicare is a complex one. The BIG hitch is that Medicare Prior Authorization is NOT a promise of payment, and therefore AOPA and the vast majority of its patient care facility members oppose it as any kind of 'solution' to audits. CMS would be severely challenged to implement prior authorization.

CMS has unfortunately seen cookie-cutter solutions for RAC audits. Therefore, two years ago CMS said—"If a demonstration project in prior authorization was acceptable for power wheelchairs (PME) in DME, let's solve the O&P audit issues the same way." A major problem is that, in reality, the PME demo project resulted in longer delays for patients. CMS insists the numbers are shorter, but reliable reports estimate that it takes between 70-100 days from the date the physician orders a power wheelchair until the prior authorization goes through and the power wheelchair reaches the beneficiary. That kind of delay simply doesn't work for the care of amputees--who, even in the delays of the RAC environment, get their replacement limbs much faster. Prior authorization may have worked for a few limited cases in the private sector if, and only if, it is an absolute guarantee of payment (otherwise, it creates its own cash flow problems). That is not true in Medicare.

Recommendations for Reasonable Reforms of RAC and Pre-Payment Audits of Claims for Artificial Limbs for Beneficiaries under Medicare Part B

Following are proposals from the Orthotic & Prosthetic Alliance to reform RAC and prepayment audits of Part B claims for artificial limbs. These are steps that definitely would assist in restoring fairness, transparency and due process as well as greatly reducing the devastation RAC and prepayment audits by CMS contractors has caused Part B claims for artificial limbs for Medicare amputees. They include:

a. Establish the prosthetist/orthotist's notes as a legitimate component of the patient medical record, comparable to a therapist;

b. Establish the prosthetist/orthotist as a recognized Medicare provider of care, distinguished from treatment as a DME supplier—the distinction between O&P and DME is clear both as O&P providers assume the role of lifetime mobility health professionals as well as being reflected in the much higher success rate when O&P appeals are decided at the ALJ level;

c. Remove the Qualified Independent Contractor (QIC) stage of the appeals process, since it takes time and virtually never results in a favorable decision for the O&P provider;

d. Advance the appeal more expeditiously to the ALJ for final action;

e. Mandate that CMS compile data on audit appeals for O&P only, separate from DME which is needed to track both the very high rate O&P RACs audit appeals and high overturn rate on appeal (CMS has consistently refused to track such data)*;

f. Establish financial penalties for RACs if an established percentage of appeal overturns occur, e.g. double interest penalties assessed against RAC, which funds along with savings from item C. above could be used to fund an increase in the number of ALJs; and

g. Address the need for more ALJs to mitigate the current backlog, either by direction to the Office of Medicare Hearings and Appeals (OMHA), which as an arm of HHS is responsible for funding for ALJs, or a statutory change to allow CMS to fund ALJ appeals for RAC determinations.

* It was underscored in the May 20 hearing before the Oversight and Government Reform Committee that overturn rates at the ALJ level run between 56% to 74% provider success in overturning RAC audit conclusions.

Unlike Part A, There Has Been No Pause or Any Relief Whatsoever from CMS as to Part B RACs.

Chairman Brady's observation in announcing these hearings noted that, "The Ways and Means Committee fought hard to ensure that patients are getting the care they need, and that Medicare is properly paying hospitals for the care they provide. While we were able to provide some relief last March, it was only a temporary fix. We must work on a permanent solution. We don't want providers unnecessarily looking over their shoulder for auditors. We want hospitals to be accurately reimbursed so that they can focus all of their time on providing the right type of care for patients."

AOPA applauds the search for a longer term solution for hospitals as those solutions in part will help address or inspire solutions for the similar audit problems facing O&P providers. An additional longer term solution for O&P through the enactment of H.R. 3112 would simply require CMS to implement section 427 of the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA), which requires CMS to only make payments to "qualified providers," as those professionals certified by the two main certification organizations, or their equivalent, in the field of O&P or properly licensed in those states requiring licensure.

Another long term solution provided by H.R. 3112 is that eligibility for payment would be linked to the qualification of the providers and the complexity of the device the patient needs. Patient quality of care then would be improved. Additionally, taxpayer dollars would be saved through a reduction in poor outcomes and repeated charges for follow up O&P care that would not be necessary if a qualified provider had served the patient in the first place.

As we indicated in our statement for the April 30 Ways & Means Health Subcommittee hearing, **many, including members of Congress, see the Part A relief for hospitals in terms of the "pause" for about a year relating to RACs under the two midnight rule, and think there has been similar relief under Part B for O&P RACs--the truth is that there has been no pause or any relief whatsoever from CMS as to Part B RACs.**

CMS Should Issue a Moratorium on Part B RAC Audits

Many suppliers affected by RAC audits are small businesses like our members. They do not have the financial wherewithal to sustain their business when RAC audits or other questionable tactics to fight fraud and abuse continue unabated. It would be our hope that the focus of these hearings on the needs of our nation's hospitals

under Part A becomes the clarion call for expanding solutions to relieve the threatening disasters that will befall small business providers under Part B if early and significant relief from Part B RAC audits is not forthcoming.

Conclusion

In conclusion, AOPA will continue to work with Congress and CMS to ensure that those who prey on Medicare beneficiaries do not find the O&P sector an easy place to establish and operate a fraud scheme. We offer our support for developing more effective means to fight Medicare fraud that does not punish legitimate suppliers who are playing by the rules. We believe that the fairest and most effective system is one that prevents fraud before it starts, and we hope that Congress will direct CMS to implement relevant provisions contained in Section 427 of BIPA and that it will pass H.R. 3112.

AOPA appreciates the Committee's efforts to work with us to find ways to better regulate our payments. We hope to continue to work with you to improve the quality of care we deliver to patients who need O&P services, and to protect the integrity of the Medicare program.