Survival of Patient Care in Prosthetic Limbs: What the White House/Executive Branch Could Do

Providing artificial replacement limbs for Medicare amputees has been in severe turmoil (over 100 patient care facilities have closed) for the past three years because of a change in Medicare policy which resulted in turn from an uninformed and misguided, August 2011 HHS OIG Report. As a window into the impact of this, prosthetics went from 97% clean claims in July, 2011 to 97% claims denied in Sept. 2011. Claims denials can occur easily when CMS simply shifts the standard without a rulemaking and applies it retroactively.

At this time, our amputee community has benefitted from new technologies developed for our vets, if they can gain access to the new limbs that have evolved from the Iraq-Afghanistan driven quantum leap in technology. Here are the steps needed from the White House and Executive branch to assure continued access to, and availability of top quality replacement limbs for Medicare amputees:

1. Patient care activities--work performed by physicians, therapists and prosthetic and orthotic professionals need to be exempted from prior authorization.

2. For purposes of audits, and all other purposes, the prosthetists' notes/records on patient encounters are a legitimate part of the medical records, on a parallel basis with those of physicians and therapists.

3. Orthotics and prosthetics patient care needs to be recognized as separate and distinct from supplying durable medical equipment, since the former delivers lifetime patient care to assure patient mobility while the latter delivers goods and commodities; AND CMS needs to be required to track all audit information--number of appeals and their success more granularly separately DMEPOS into separate breakdowns for DME and O&P.

4. RAC audits, Part A and B, that are not directly related to demonstrated fraud must be suspended until HHS can show adherence to the legal requirement for an decision on appeals to the Administrative Law Judge level within 90 days of request, otherwise appeals (estimated 1 million backlogged claims by year-end) will continue to balloon.

5. Medicare Prior Authorization needs to constitute a promise of payment AND all RAC, prepayment and other audits need to be terminated in those instances where prior authorization has been secured (that is, has been required by Medicare) in the absence of demonstrated evidence of fraudulent billings.

6. Provisions of H.R. 3112 relating to prohibition of Medicare payment to unlicensed and unaccredited providers need to be implemented in final rule before the end of 2014.