American Orthotic &
Prosthetic Association

Overview of the O&P Pre-Payment & Post-Payment Audit Concerns

Background

In August of 2011 the Health and Human Services Office of Inspector General (OIG) released a report, which was premised on a severe misunderstanding of the orthotic and prosthetic patient care delivery model, and the report indicated that there appeared to be an abundance of fraudulent billing, especially for lower limb prostheses. CMS accepted most of the major findings of the OIG report, without correction or rebuttal, and used the allegations of fraud to create new requirements mandating that O&P providers must have expanded documentation from the referring physician; which is often lacking in detail, is not available or the physician is unwilling to provide. CMS took this stance, even though the Office of Program Integrity 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.

As a result of this report:

1. CMS contractors, including the Recovery Audit Contractors (RAC) and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC), who appear to operate without rules or supervision, by "announcing" new standards without reference to the Administrative Procedure Act (APA) and without the benefit of rulemaking, have applied the newly announced physician documentation standards retrospectively to claims; when the provider could have no knowledge of the standard at the time services were rendered.
2. Unleashed a "gotcha" mentality and unrealistic RAC audit practices that denied Medicare claims based frequently on minor technicalities or physician documentation requirements. Claims that were valid just months before the report was released were now denied, with no evidence of fraud. The majority of these denied claims that providers have appealed have been reversed at some level of appeal, even if it takes up to two years, demonstrating there was no fraud. (The increase in the denials and appeals due to the audits for physician documentation is a large factor in the outlandish and unlawful Administrative Law Judge (ALJ) delays).
3. Triggered a wave of massive pre-payment audits, being conducted by the DME MACs, on nearly all O&P claims submitted to Medicare; in some cases severely diminishing the

cash-flow of small O&P businesses (annual total sales of roughly $1 million) and making their financial situations dramatically worse. In the worst case scenario the audits have forced the closing of O&P patient care facilities resulting in fewer providers and choices for patients.

4. CMS contractors will routinely secure substantial caches of additional physician documentation; however it is misused as rationale for detached audit personnel, generally without either credentials or experience in orthotics or prosthetics, who have never seen the patient, to countermand the prescription and care orders of the physician who has the responsibility for the overall clinical care of the patient.

Where We Are Now

There are pieces of legislation currently being introduced in the 114th Congress that address many of the auditing issues facing orthotic and prosthetic professionals, in the era of rampant unrealistic “gotcha” RAC audit practices, and provide a means to create a more accurate picture of where in the Medicare Part B program fraud is taking place. These pieces of legislation would create greater transparency and accountability among CMS’ audit contractors and restore legitimacy to the O&P healthcare provider by:

1. Providing fair and equal weight to certain documentation created by orthotists and prosthetists. “For purposes of determining under this title the reasonableness and medical necessity of prosthetic devices and orthotics and prosthetics, documentation created by orthotists and prosthetists relating to the need for such devices, orthotics, and prosthetics shall be considered part of the medical record”. (This modest change in language would increase patient’s access to care and eliminate a large number of claims that are being denied due to lack of notes in the medical record. Prior to the inception of the current CMS audit policy in August of 2011, Medicare relied on the patient evaluating notes of the orthotist and prosthetist to determine medical necessity.)

2. Requiring the Department of Health and Human Services to create separate categories for orthotics and prosthetics (O&P) and for durable medical equipment (DME); when compiling and publicly reporting information on appeals filed and success of appeals for providers at ALJ level. (This would provide concise data on which claims (O&P or DME) are being appealed and the success rate of those appeals).

3. Requiring the Center for Medicare and Medicaid Services, or any of its contractors, to exclude claims for payments that have been denied and are being appealed by a provider or supplier when calculating payment error rates. (This would allow for a more accurate and fair error rate.)

The audits should be designed and carried out to uncover fraud and abuse; not to foster “gotcha” denials adversely affecting patient care.

Recommendation

Communicate your concerns as a Member of Congress: (1) by signing onto the joint, bipartisan Congressional letter to Secretary Burwell and acting CMS Administrator Slavitt pressing them to assure a timely implementation of the BIPA 427, now long overdue, so as to define qualified providers, and thus clarify the legitimacy of the prosthetist's notes/records; and (2) join in support, by becoming a co-sponsor, of the following legislation being introduced in the 114th Congress:

- The Medicare O&P Improvement Act of 2015
- The Medicare DMEPOS Audit Improvement & Reform Act (HR 5083 in the 113th Congress)
- The Hospitals Improvements Payment Act
- The Strengthening of Orthotics & Prosthetics in Medicare Act

Help restore the legitimacy of the documentation by certified or licensed professionals in the O&P profession, and separate orthotics and prosthetics from durable medical equipment for reporting appeals information and calculating error rates; and take a stand against the undue burden, caused by the overzealous RAC and pre-payment audits, being placed on small healthcare providers and Medicare beneficiaries.

For more information contact the American Orthotic & Prosthetic

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