



**American Orthotic &  
Prosthetic Association**

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## AOPA 1<sup>st</sup> Quarter 2013 Staff Report

**To: AOPA Membership**  
**From: Thomas F. Fise, Executive Director**  
**Date: April 18, 2013**

**Subject: Every Effort Counts!**

While many threats and challenges remain in 2013, AOPA continues to fight tooth and nail to protect our members. This 1<sup>st</sup> Quarter Staff Report will highlight the numerous steps AOPA is taking on the all too familiar Medicare RAC Audit/physician documentation issues. Further, this report will cover the 2013 Policy Forum, updates on O&P related legislation, Medicare Medical Policies Updates, the 2013 World Congress, AOPA education, membership and communications efforts and much more.

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### **Government Relations**

#### **RAC Audits**

The excessive and unfair RAC and prepayment audits plaguing the O&P industry pose one of the biggest challenges for our profession. The onset of these issues started with the August 2011 OIG Report titled, "Questionable Billing Practices in Lower Limb Prosthetics." Since then AOPA has been fully involved in a continuous battle aimed at mitigating the grievous damage these audits are causing. AOPA's efforts to find a remedy to these overly aggressive audits include numerous communications and meetings with the CMS Administrator, various CMS Directors, the OIG, and Congressional offices. In March, AOPA sent four letters to George Mills, Director, Compliance Provider Group, CMS, requesting CMS' intervention to reverse and rectify inappropriate actions taken recently by Medicare contractors relating to amputee Medicare patient/beneficiaries and the care they receive from prosthetic and orthotic providers. George Mills responded to the letters, with the response to the final two letters arriving in mid-April. AOPA continues to evaluate, assess and challenge the meaning of CMS' response to our concerns.

AOPA also reached out to survey our members to solicit feedback on their personal experiences with the burdensome audit practices. It seems likely that CMS' efforts to address the audit concerns include

moving towards a physician template and issuing a proposed regulation expected sometime after April. While the rulemaking approach represents a possible solution the process may take six months to a year and AOPA members need relief now!

AOPA continues to carefully consider all possible remedies, including the prospect of bringing a legal action. You may recall reading in the 4<sup>th</sup> Quarter Staff Report the formal letter to CMS from Attorney Tom Mills laying out the perceived breaches of proper CMS procedures and policies. Attached you will find a second letter from Attorney Tom Mills to HHS Secretary Sebelius and CMS acting administrator Marilyn Tavenner further addressing these concerns. We will continue keeping our members apprised of our efforts as we endeavor to find a workable solution to the madness.

### ***Jurisdiction A RAC Contractor Acknowledges and Corrects Calculation Error***

As a result of AOPA's March 8 letter to George Mills of CMS, Performant Recovery recently acknowledged a calculation error and contacted affected suppliers to inform them of a reduction in the number of claims subject to RAC audits. As some background, Performant Recovery, Inc, the RAC contractor for Jurisdiction A, incorrectly applied the provider based additional documentation request (ADR) calculation methodology to DMEPOS suppliers. This included suppliers who submitted claims to the DME MACs for orthotic and prosthetic services. AOPA's letter from Joe McTernan pointed out that Performant was applying to O&P facilities the higher numbers of possible audits that are applicable to DME suppliers, when in fact the regulations stipulate a lower threshold for O&P. The maximum number of ADRs for suppliers within a 45 day period has been limited to 10% of all claims submitted for the previous full calendar year, divided into eight periods. Prior to the most recent update, the maximum number of ADRs within a 45 day period for a single Tax ID was 250. George Mills acknowledged the Jurisdiction A error, and assured Performant's corrective action.

Subsequently, in a communication distinct from, but contemporaneous with the challenge from AOPA, CMS announced that, effective April 3, 2013; it modified the number of Additional Documentation Requests (ADRs) that a RAC auditor may make for DMEPOS suppliers. For most DMEPOS suppliers, the limits remain unchanged from last year. The number of ADRs a RAC may make per 45 days is limited to 10% of all claims submitted under a single Tax ID for the previous calendar year, divided by 8. For suppliers who are classified in categories 52, 53, 56, or 57 however, there is a limit of no more than 10 ADR requests per 45 days. The provider taxonomy codes mentioned above are defined as follows:

- 52—Medical Supply Company with Prosthetist
- 53—Medical Supply Company with Orthotist-Prosthetist
- 56—Individual Certified Prosthetist
- 57—Individual Certified Prosthetist-Orthotist

This modification is a significant development in AOPA's efforts to challenge the egregious and aggressive audit practices that RAC auditors have been using. The modification will benefit some O&P providers more than others. While it does not represent a comprehensive solution it does represent an acknowledgement of the negative impact RAC audits have had on the provision of medically necessary services by qualified O&P professionals. AOPA contacted CMS and requested that they also consider a similar limit of no more than 10 ADRs per 45 days for suppliers classified as follows: 51—Medical Supply Company with Orthotist; 55—Individual Certified Orthotist. In April, CMS responded to AOPA's request indicating that the RAC audit limits are being updated to include taxonomy codes 51 and 55.

### ***AOPA Continues To Survey Membership Regarding RAC Audits***

Due to the overwhelming response to last year's AOPA RAC Audit Survey in fall, 2012, AOPA re-issued the survey to obtain updated information regarding the success AOPA members are having when appealing RAC audit denials. While many claims are still at some stage of the appeals process, AOPA is

encouraged by the relatively high success rate that AOPA members are reporting when appealing RAC audit denials, especially at the Administrative Law Judge level. The survey also revealed another negative impact of RAC and pre-payment audits --caught in the pressure between long battles, delays, documentation request and pre-payment audits for advanced prosthetic technologies and time pressures to deliver the patient a prosthesis has frequently resulted in not providing Medicare beneficiaries with the most appropriate, more advanced technologies.

### **2013 Policy Forum**

The 2013 AOPA Policy Forum was a great success for members and the O&P community. The first day provided attendees intensive information sessions about the condition and trajectory of O&P amid a very challenging political environment. The second day consisted of Congressional visits with AOPA members' representatives. Over 100 AOPA members attended this dynamic event.

Rep. Tammy Duckworth (D-IL) served as the opening keynote speaker. Closing up the educational sessions of the Policy Forum was Rep. Brett Guthrie (R-KY). Reps. Guthrie and Duckworth are both fired up over the unfairness of the CMS contractor audit process and how it is imperiling patient care - not to mention your business. They are playing pivotal roles with their efforts to garner support from Representatives to sign-on to a letter to Secretary Sebelius. The sign-on letter to Secretary Sebelius urges the Secretary to "find a way to develop policies that allow CMS to eliminate true fraud and abuse, while not slowing payment to providers so significantly that they cannot function."

AOPA members' legislative visits during the Policy Forum helped to lay the groundwork with legislators for this initiative. Subsequently, AOPA pushed out a campaign urging all members to contact their legislator to request the legislator sign-on to the Sebelius letter. The O&P community response was impressive with over 1,700 request letters sent to over 375 legislators. Attached you will find a copy of the letter to Secretary Sebelius authored by Reps. Duckworth and Guthrie which garnered 35 co-signers. Thank you to those that attended the Policy Forum and those that took the time to contact their legislator in response to the AOPA request. Your voice matters!

Additionally, the 2013 Policy Forum would not be possible without our sponsors. A BIG thank you to the following sponsors for their support of this year's event!

- Becker Orthopedic
- Fillauer Companies
- Townsend Design
- Freedom Innovations
- OPGA
- Tamarack Habilitation Tech., Inc.
- Kinetic Research
- Pel Supply Co.
- SPS
- KISS
- Ottobock
- WillowWood
- Cailor Fleming
- TRS, Inc.
- Anatomical Concepts

### **Legislative Efforts**

A continued effort is underway to introduce the 113<sup>th</sup> Congress versions of the O&P Medicare Improvements Act and the Insurance Fairness for Amputees Act. The Injured and Amputee Veterans Bill of Rights is another candidate for re-introduction in the 113<sup>th</sup> Congress. With regard to the O&P Medicare Improvements Act, efforts are being made to obtain data regarding unlicensed providers in licensure states receiving payment under Medicare despite the fact that in providing such care they violated state law. Additionally, a meeting was held with AOPA lobbyists to discuss the impact of the Affordable Care Act on proposed language for the Insurance Fairness for Amputees Act.

### **Survival Imperatives**

In July 2012, our Board of Directors identified several threats and opportunities related to the O&P industry. After collaborating with related communities, we created six committees to tackle these

challenges. These “Survival Imperative Streams” are each headed by AOPA board members or other qualified O&P professionals. The latest meeting with these leaders was held on March 14, 2013 to continue work on these committees.

### **Stream 1: Patient Intakes, Outcomes, and Data Collection**

*Led by Paul Prusakowski, CPO, FAAOP and Tom DiBello, CO, FAAOP*

- This stream is developing a longitudinal database to describe the demographics, etiologies, treatment, and progress of our patients. The goal is to incorporate basic intake forms, to use this data to develop best practices and establish a data repository.

### **Stream 2: Outcomes/Evidence-based Practice**

*Led by Jim Campbell, PH.D, CO and Tom DiBello, CO, FAAOP*

- To better coordinate treatments and episodes of care, AOPA awarded 2 research grants to qualified researchers to perform systematic literature reviews to develop a series of best-practice guidelines and expert panels have been established to translate the results into evidence-based best practices statements. The 2 specific areas identified are transtibial amputations and the use of orthotics in stroke recovery.

### **Stream 3: Cost & Comparative Effectiveness**

*Led by Anita Liberman-Lampear, MA*

- To identify unanswered research questions and ultimately to determine how to achieve valid answers, AOPA obtained Medicare data on 4 years of all O&P episodes of care, which is currently being analyzed to glean as many possible research answers from retrospective evidence derived from Medicare data. Preliminary data runs demonstrate cost savings of early O&P intervention. Ultimately, priority areas for new outcomes and comparative effectiveness studies will be identified for possible support.

### **Stream 4: Education and Communications**

*Led by Scott Schneider*

- This stream targets the payer community, to identify any knowledge gaps relating to O&P, and then to educate payers at major insurance companies and officials at the federal/state health care level about who we are and what we do.

### **Stream 5: Alliances**

*Led by Michael Oros, CPO, FAAOP*

- This stream is identifying important allies in healthcare delivery models. Partnering with other similarly situated providers may help O&P master the healthcare delivery models introduced by the Affordable Care Act and state level delivery models.

### **Stream 6: Risks/Reimbursements**

*Led by Mike Hamontree*

- This stream is exploring alternative delivery methods for O&P by examining risk sharing models currently in use or being considered for implementation, for example monitoring ongoing CMS demonstration projects on acute care bundling. These efforts look at care bundling Diagnoses Related Group approaches and CMS innovation care models to find ways to measure quality of care to predict the most patient/provider friendly care models.

## **Education and Research**

### ***Legislation introduced in Senate to Support Prosthetic Research***

AOPA’s legislative consulting firm, Linchpin Strategies, continues to work with Members of Congress on obtaining funding to support masters level O&P education programs and has received interest from Senator Blumenthal’s and Senator Durbin’s office to introduce legislation that would support this objective. Subsequently, Senator Durbin introduced *S. 521, the Wounded Warrior Research Enhancement Act* and *S. 522, the Wounded Warrior Workforce Enhancement Act*. The impetus behind these efforts to allocate and coordinate more research dollars (\$30 million) to prosthetic research acknowledges that our field has important, unanswered questions with significant cost implications for DoD, the VA, Medicare and health care more generally.

### ***Small Grant RFP***

The leadership of AOPA, working in conjunction with the Center for Orthotic and Prosthetic Learning and Outcomes/Evidence-Based Practice (COPL) and its Board of Directors, recognizes that there is a modest amount of original evidence-based or outcomes research in orthotics and prosthetics. To address this issue, AOPA is currently soliciting proposals for funding original pilot research that will lead to larger trials that may qualify for government or other research funding support in nine areas of O&P. Grants of \$15,000 each will be awarded four research projects based on recommendations made by the COPL Board of Directors to AOPA's Board.

### **Medicare Prepayment Review Results**

The DME MACs either announced the establishment or published the following results of Pre-Payment review activity during the first quarter of 2013.

#### ***Jurisdiction B: All high cost DMEPOS***

Jurisdiction B continues to perform pre-payment reviews on all high dollar DMEPOS claims, including O&P claims. For many providers this has resulted in virtually 100% pre-payment audits of prosthetic claims. AOPA is very active in working with members and Jurisdiction B medical review staff to address this issue and the serious implications it has on cash flow for AOPA members. In January 2013, AOPA participated in the Jurisdiction B DME MAC Advisory Council meeting. At this meeting, Jurisdiction B officials indicated that providers with a proven record of continued success in pre-payment audits could, on an individual basis, request removal from the audit pool. While a few AOPA members have successfully completed this process, AOPA continues to work with Jurisdiction B and CMS on a more permanent solution to this issue.

#### ***Jurisdiction C: K3 Prosthetic Components***

Cigna Government Services (CGS), the Jurisdiction C DME MAC, recently published results of its ongoing widespread prepayment review of prosthetic claims that include K3 or higher functional level components. From August 2012 through December 2012, the overall error rate decreased from 74.2% to 66.0%. While this represents a significant reduction on the overall error rate, according to CGS it remains high enough to warrant the continuation of the widespread prepayment review. Of the claims that were denied, CGS reported that 44% were denied due to a lack of documentation in the physician's records that support the medical need for the prosthesis, 22% lacked documentation that supported the need for K3 functional level components, 3% lacked a proper functional level assessment, and 3% lacked proper proof of delivery.

#### ***Jurisdiction D: Prosthetic Feet Described by Codes L5980, L5981, and L5987***

The Jurisdiction D DME MAC recently announced that they will be conducting a widespread prepayment review for the following three HCPCS codes:

L5980—All lower extremity prostheses, flex-foot system

L5981—All lower extremity prostheses, flex-walk system or equal

L5987—All lower extremity prosthesis, shank foot system with vertical loading pylon

AOPA protested this announcement as a thinly veiled attempt to encourage O&P practitioners to provide lesser technology prosthetic feet to Medicare beneficiaries in one of the four letters sent to George Mills, CMS Director, Provider Compliance Group.

#### ***Jurisdiction D: External Breast Prostheses***

The Jurisdiction D DME MAC completed a prepayment probe review of external breast prostheses described using procedure code L8030. The prepayment review consisted of 95 claims of which 68 were

denied, resulting in an overall error rate of 76%. Of the claims that were denied, 22% were denied due to a lack of documentation within the patient's medical record, 19% were denied due to a lack of support of medical necessity within the medical record, and 17% were denied due to an invalid proof of delivery form. As a result of the high error rate established by the probe review, Jurisdiction D announced that it will initiate a widespread prepayment review of claims for external breast prostheses.

#### ***Jurisdiction D: L5301 and L5673***

On March 5, 2013 the Jurisdiction D DME MAC announced that it is closing the pre-payment probe review for codes L5673 and L5301.

#### **Medicare Medical Policy Updates**

##### ***LSO/TLSO Policy Revisions***

The Medicare LSO/TLSO policy has been revised, and the revisions took effect on January 1, 2013. The policy now includes coverage directions for code L0621 (SO, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment).

For claims with a date of service on or after January 1, 2013 for an item described by code L0621, the claim must include the CG modifier to be considered for payment. The CG modifier should only be applied if the item you are providing is constructed primarily of non-elastic materials (e.g. cotton, nylon, canvas) or contains a rigid posterior panel.

##### ***AFO/KAFO Policy Revision***

The DME MACs published a revision to policy effective January 1, 2013 that would have placed height restrictions on AFOs described by codes L1900 and L1910-L1990. AOPA immediately protested this policy and as a result of AOPA efforts, the policy was rescinded by the DME MACs retroactively to the proposed implementation date.

##### ***AOPA Response to OIG Report on Medicare Payments for L0631***

On January 8, 2013, AOPA provided comments related to the December 2012 OIG report entitled, "Medicare Supplier Acquisition Costs for L0631 Back Orthoses." This letter, signed jointly by AOPA President Tom Kirk, Ph.D and AOPA Executive Director Tom Fise, JD, strongly disagreed with the OIG recommendations that CMS consider either fee reductions under inherent reasonableness or via competition as the most appropriate methods of controlling cost and utilization associated with orthoses described by L0631. AOPA voiced concerns regarding the fact that L0631 devices do not meet the statutory criteria for off-the-shelf devices, namely items that require "minimal self adjustment," and therefore the code could not legally be subjected to competitive bidding. AOPA believes that orthoses described by L0631 require appropriate fitting and adjustment by trained professionals who have the proper knowledge, education and experience necessary to ensure their proper fit and function.

On April 3, 2013, AOPA received a response from Stuart Wright of the Inspector General's Office that is currently being reviewed. Additional communication regarding this issue is expected as AOPA continues to challenge the assertions made in the original report.

##### ***Lower Limb Prosthesis Policy Revision***

Each of the four DME MACs published revised correct coding instructions for microprocessor controlled knee (MPK) systems. The revision expands upon previous coding guidance for microprocessor controlled knees by providing coding guidance for specific brand name systems. The revision reiterates that there is no separate billing for programming associated with these systems, electronically controlled stance regulation, or continuous gait assessment.

The lower limb prostheses policy was updated to address the documentation requirements and coverage criteria for code L5859, a new code for 2013. L5859 is an addition to lower extremity prosthesis,

endoskeletal knee shin system, powered and programmable flexion/extension assist control, includes any type motor(s). In order for an L5859 to be considered medically necessary for a Medicare patient, the patient must meet the following criteria:

1. Has a microprocessor (swing and stance phase type (L5856)) controlled (electronic) knee
2. Is a K3 functional level
3. Weighs greater than 110 lbs and less than 275 lbs
4. Has a documented comorbidity of the spine and/or sound limb affecting hip extension and/or quadriceps function that impairs K-3 level function with the use of a microprocessor-controlled knee alone
5. Is able to make use of a product that requires daily charging
6. Is able to understand and respond to error alerts and alarms indicating problems with the function of the unit.

If any of the above listed criteria are not met, L5859 will be considered not medically necessary and will be denied by Medicare.

#### **PECOS Edits for Ordering/Referring Physicians to be Implemented May 1, 2013**

The Affordable Care Act established the PECOS requirement for referring providers, but implementation was delayed. Since 2009, claims that involved a non-PECOS enrolled physician were processed with a warning message that the referring provider was not in PECOS.

Recently, CMS announced that Medicare claims with a date of service on or May 1, 2013 will be subject to edits that will ensure that there is an active PECOS profile for the referring /ordering physician. Claims where there is no PECOS record for the referring/ordering physician will be rejected and returned to the provider as unprocessable. The earlier CMS effort to reject DMEPOS claims based on the physician not having filed the PECOS paperwork was delayed so that CMS could develop a reliable, accessible database listing information on whether physicians were or were not properly PECOS registered. Obviously, the availability of such a database is a necessary prerequisite to CMS enforcement.

#### **Federal Sequestration Leads to 2% Reduction in Medicare Reimbursement**

A 2% reduction in all Medicare reimbursements will be applied effective for claims with a date of service on or after April 1, 2013. The 2% reduction applies to all provider types including, but not limited, to DMEPOS suppliers, hospitals, physicians, therapists, etc. The 2% reduction arises under the deficit-reduction sequestration rules enacted in August, 2011 taking effect. The only positive factor is that those rules apply a 2% limit to Medicare reductions averting higher cutbacks applicable to other government agencies.

Importantly, the 2% reduction will be applied after calculating any applicable coinsurance or deductible. This means that patients remain financially responsible for the full 20% of the traditional Medicare allowable plus any unmet deductible for 2013.

#### **HIPAA Changes**

The Department of Health & Human Services (HHS) recently published the Omnibus Rule, which makes updates/modifies the HIPAA Privacy, Security, Enforcement Breach Notification Rules; that were originally published as part of the Health Information Technology for Economic and Clinical Health Act or HITECH Act. Some of these updates include:

- Expanding the definition and liability of a Business Associate
- Redefining what is considered a breach of Protected Health Information (PHI)
- Changes what is considered a permissible use and disclosure of PHI
- Expansion of a patient's rights to access their PHI

These new rules become effective on March 26, 2013, however you have until September 23, 2013 to become fully compliant. These changes are being covered in more depth in the April and May editions of the O&P Almanac as part of a two-part series. Be sure to check it out!

### **HHS Releases Final Rule on Essential Health Benefits (EHB)**

HHS released the final rule on Essential Health Benefits on February 20, 2013. Previously, AOPA submitted comments on the proposed rule detailing the legislative history that supports the inclusion of O&P within the statutorily covered category of rehabilitation and habilitation services and devices. AOPA also expressed concerns about ambiguities with the proposed benchmark plan approach delegating the determination of the EHB package to the states.

The final rule largely adopts the provisions of the proposed rule utilizing an EHB Benchmark Plan approach. This approach relies on an EHB benchmark plan serving as a reference plan for determining the scope of services to be offered by plans within the health insurance exchanges. States have the option of choosing a base-benchmark plan from four plan categories (which may total up to 8 different plans) or a default plan will apply. The applicable default plan is the largest Federal Employees Health Benefits Plan, except for in Puerto Rico. While AOPA pushed for more clarity on the proposed approach, HHS adopted the less-defined approach citing the reason as providing states flexibility to select the details of the state's EHB coverage.

On the upside, HHS retained the proposed language providing that if a plan fails to cover habilitative services insurers either must provide "parity" or must craft a benefit and report on that coverage to HHS.

AOPA supports this effort to ensure coverage within states' EHB benchmark plan of the Habilitative prong of the statutorily defined Rehabilitative and Habilitative category of services, but we remain concerned that a plan which offers some O&P benefit, but which offers only a seriously deficient plan in terms of O&P coverage, may still meet federal guidelines.

### **AOPA Coding Products**

The top-selling 2013 *Quick Coder, Illustrated Guide* and *Coding Pro* were released for sale early in 2013. Staff is available to provide technical support for the *Coding Pro* product.

### **AOPAversity**

#### ***Mastering Medicare: Essential Coding and Billing Techniques Seminar***

AOPA presented two Advanced Coding and Billing Techniques Seminar in 2013 with two additional seminars scheduled for June 13-14 in Phoenix, AZ and October 22-23 in Las Vegas, NV. The first seminar of 2013, in Atlanta, GA, was extremely well attended with over 100 participants.

#### ***AOPA Mastering Medicare Audioconferences***

AOPA's monthly Mastering Medicare Audioconference series consist of one hour, interactive sessions. These sessions provide AOPA with the opportunity to communicate important information about current issues affecting the AOPA membership. Attendee feedback indicates this on-going series is a valuable resource to the AOPA membership. Upcoming sessions will be held at 1 p.m. EST and include the following topics:

- May 8<sup>th</sup>, Navigating the Maze- Get to Know the Appeals Process
- June 12<sup>th</sup>- Clinical Documentation: Do's & Don'ts
- July 10<sup>th</sup>- Networking for the Future: Building Relationships with Your Referrals

### **AOPA Advocacy**

#### ***AOPA Testifies in Opposition to Texas Legislative Proposal Harmful to O&P Providers***

AOPA staff member Lauren Anderson, MPH, testified on March 12 in Austin, Texas, against SB 505, which would allow practitioners exempted from Texas licensing requirements to extend their exemption



to anyone under their supervision. This bill contained broad language that could allow abuse and potentially untrained persons to perform complex orthotic fittings. Opponents testified to the potential harm to patients citing the complex nature of care for some orthotic patients, past incidents of improper fittings, and the broader implications of this bill.

The Senate took the opposition's concern into consideration, and solicited new language from the opponents, including Texas Association of Orthotics & Prosthetics, the Texas Chapter of AAOP, and AOPA to narrow the exemption. The new language only allows physicians to extend their exemption; does not extend the exemption to custom-fabricated orthotics if the fitting requires substantial clinical judgment as designated by the treating physician. The bill is currently pending in committee and is expected to be passed in its revised form.

### ***Patient Centered Outcomes Research Institute (PCORI)***

PCORI is a private entity created by the Affordable Care Act, designed to conduct evidence-based research to facilitate informed decision-making by patients and their health care providers.

AOPA is working to build a relationship with PCORI to explore any common research interests and opportunities.

### ***PAC Donors***



### ***2013 O&P PAC HONOR CLUB MEMBERS***

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Once again, AOPA is pleased to publish and thank AOPA's own roll call of leaders who help sharpen our advocacy tools through their support of the O&P PAC. This list covers the period from April 1, 2012 through March 31, 2013. If we missed your name please accept my apologies. We would like to thank the following individuals for their contributions to the O&P PAC, the political action committee representing you and the O&P community, on Capitol Hill. The O&P PAC provides you with a means of increasing the visibility and recognition of orthotics and prosthetics among legislators. It allows individuals to unite and pool their resources to support candidates for federal office who understand the crucial role of O&P in the health care delivery system. As of March 31, 2013 the O&P PAC raised almost \$20,000 for the 2013 calendar year.

**Contributions made between April 1, 2012 through March 31, 2013. O&P PAC Contributions made in 2013 will be denoted as such.**

**President's Circle (\$1,000-\$5,000)** Michael J. Allen, CPO, FAAOP; Robert E. Arbogast (2012 & 2013); Kel M. Bergmann, CPO; Donald Buethorn (2013); Maynard Carkhuff (2012 & 2013); Ronald Cheney; Thomas V. DiBello, CO, LO, FAAOP (2012 & 2013); Mike Fenner, CPO, BOCPO, LPO (2012 & 2013); Rick Fleetwood, MPA; Michael Gozola, CP; Russell J. Hornfisher, MBA, MSOD; Harry W. Layton, CPO, LPO; Jon P. Leimkuehler, CPO, FAAOP; Robert V. Leimkuehler, CPO; Mark T. Maguire, CPO (2012 & 2013); Gary Mahler; Patricia Petersen; Walter Racette, CPO; John A. Roberts, Jr., CPO; Scott Schneider; Rick Stapleton, CPO (2013); Gordon Stevens, CPO, LPO; Paulette Vaughn (2012 & 2013); Bernie Veldman, CO; Frank Vero, CPO; James Weber MBA; James O. Young, Jr., CP, LP, FAAOP (2012 & 2013).

**Senator's Table (\$500-\$999)** Sherrie Anderson, CP, LPO (2013); J. Martin Carlson, CPO, FAAOP; Glenn Crumpton, CPO, C.Ped.; Edward De LaTorre; Ed H. Gildehaus, III, C.Ped., CPO, FAAOP; Michael E. Hamontree; Ronald Hercules (2013); Alfred E. Kritter, CPO, FAAOP; Ellen Leimkuehler; William J. Leimkuehler, CPO, LPO (2012 & 2013); Marlon Moore, CO; Ted Muilenburg, CP, LP; Rodney M Pang, CPO; Ron Pawlowski, CPO (2013); Gerri Price, CFom, C.Ped.; Jack Steele (2013); Ashlie White; Jeffrey J. Yakovich, CO.

**Chairman's Table (\$100 - \$499)** Rudy Becker, Sr.; Robert Biaggi, CPO; Jeffrey M. Brandt, CPO; George Breece (2012 & 2013); Terri Bukacheski, CP, LP; Alan R. Burke, BOCO; Erin Cammarata, RTO; Kenneth Cornell, CO; Charles H. Dankmeyer, CPO; Don J. DeBolt; William A. DeToro, CPO; Mark F. Devens, CPO; Martin Diaz, BOCO, C.Ped.; Ted Drygas, CPO; David Falk, CPO; James Fenton, CPO; Michael Hall, CPO, C.Ped.; Joseph Huntsman, MBA, MA; Fran Varner Jenkins; Marc N. Karn, CP; John M. Kenney, CPO, FAAOP; Thomas Kirk,

Ph.D.; Eileen Levis; Pam Lupo, CO; Ann Mantelmacher; Lee Mantelmacher, CPO; Michael Martin, CO, FAAOP (2013); Clyde Newton Massey, CPO (2012 & 2013); Brad Mattear, CPA, CFP (2012 & 2013); Steve McNamee, CP, BOCO, FAAOP; Steven A. Mirones, CO, C.Ped., FAAOP (2012 & 2013); Michael Oros, CPO, LPO; James Price, Jr., Ph.D., CPO, C.Ped., FAAOP; Ed Reyes, CPO, LPO (2013); Stephen Rinko, BS, CPO (2013); John Ruzich, CP, LP; Jeff Smith, CPO (2013); Mark Smith, CP; Chris Snell; Peter Thomas, Esq. Joan Weintrob, CPO; Steve Whiteside, CO, FAAOP; Jon D. Wilson, CPO; Claudia Zacharias, MBA, CAE (2012 & 2013).

**1917 Club (Up to \$99)** J. Laurence Allen, CPO; David Bow, CPO; Jim Campbell, Ph.D., CO, FAAOP; Maureen Canter; Frank Caruso, CO; Melvin Cunningham; Joe Davant; Jason Eddy; Jeff Erenstone, CPO; Troy Fink; John Galonek, CO; Carey Glass, CPO, FAAOP; Eddy Gosschalk, CPO; Garrett Griffith; April Groves, CO; Rita Hammer; David A. Johnson, CO; Rahul Kaliki, PhD; Paul Macy, CPO; Salvatore Martella, CPO; Kathy Mascola, CPO, BOCO; Kevin Matthews, CO, LO; Sean McKale, CO; Nina Miller; George Newton, CPO; Daryl Reuter; Eric Schopmeyer, CO; Anthony J. Squicciarini, CPO, C.Ped.; Jeff Wensman CPO.

**Special Support Group** – *Each year, the O&P PAC organizes fundraising events for members of Congress who have been supportive of O&P. For each event AOPA members make a personal contribution to the member's campaign and spend time with the member talking about a variety of issues including health care and the provision of O&P. These events are a unique way to share O&P concerns, get to know a member of Congress and get a congressional update, and have been very successful in getting Congress to understand O&P concerns. Also, each year the O&P PAC sponsors events which allow AOPA members to learn more about the activities of the PAC, and provides them with the opportunity to get involved. We would also like to thank those individuals who in the past year have donated directly to a candidate's fundraiser or to an O&P PAC sponsored event are valuable supporters in achieving the legislative goals of AOPA and the O&P PAC.*

Ryan Arbogast; Ryan Ball; Rudy Becker, Sr.; Kel M. Bergmann, CPO, Frank Bostock, CO; Brightree, LLC; Victor Bustamante, CP; Kendra Calhoun; Jim Campbell, PhD, CO, FAAOP; Luis Carbajal; Maynard Carkuff; Dennis Clark, CPO; Jeff Collins, CPA; Thomas J. Costin; Rob Cripe; Charles Dankmeyer, CPO; Don DeBolt; Thomas V. DiBello, CO, LO, FAAOP; Jim Fenton, CPO; Thomas F. Fise, Esq.; Rick Fleetwood, MPA; Nancy Gagne; Richard & Marbee Gingras; Eddy Gosschalk; Catherine Graf, Esq.; Paul Gudonis; Tom Guth, CP; Darlene Hall, C.Ped.; Michael Hamontree, MBA; Hanger PAC; Russell Hornfisher, MPA, MSOP; Joe Huntsman, MBA, MA; James Kaiser, CP, LP; Marc Karn, CP; Patricia Kaviani; Steve Kelly; Mark Kenney, CPO; Tonya Kettering; Tom Kirk, Ph.D; Anthony Korjagin, CP; Alfred E. Kritter, CPO, FAAOP; Teri Kuffel, Esq.; Scott Langston; Robert V. Leimkuehler, CPO; Jon P. Leimkuehler, CPO, FAAOP; Paul Leimkuehler; William Leimkuehler, CPO; Eileen Levis; Anita Liberman-Lamphear, MA; Pedro Llanes, CPO; Ronald Longo, CP; Pam Lupo, CO; Alexander Lyons, CPO; Catriona Macdonald; Ron Manganiello; Ann Mantelmacher; Mollie Matthews; Megan Matjevich; Doug McCormack; Joe McTernan; Steven A. Mirones, CO, C.Ped.; Tina Moran; Dominique Mungo; Michael Oros, CPO, LPO; Ed Peguero, BOCO; Patricia Petersen; Anthony Potter; Proteor; Walter Racette, CPO; Rick Ramos, CP, LP, C.Ped.; Michael Richard, CPO; John Roberts, Jr., CPO; Luke Rogers, CO, BOCF; Rick Riley; Bradley N. Ruhl; Brett Saunders, CPO, FAAOP; Jan Saunders, CPO; Joyce Schlemmer; Scott Schneider; Brian Smith, BOCO; Chris Snell; William C. Snell, CPO; Jan Stokosa, CP, FAAOP; Peter Thomas, Esq., Randall Valverde; Frank Vero, CPO; Ben Walker, BOCPO, LPO; Tom Watson, CP; James Weber, MBA; Ashlie White; Daryl Williams; Connie Withers; James O. Young, Jr., CP, LP, FAAOP; and Claudia Zacharias, MBA, CAE.

### **2013 O&P World Congress**

The 2013 O&P World Congress will be held Wednesday, Sept. 18 – Saturday, Sept. 21 at the Gaylord Palms Resort and Convention Center located in Orlando, Florida, USA. Already the most talked about event for 2013—it is the premier destination for the world-wide orthotic and prosthetic community. Register today at [www.opworldcongressusa.org](http://www.opworldcongressusa.org) to participate in an expanded National Assembly as AOPA and partners from around the world work to create an O&P World Congress experience for practitioners in the Western Hemisphere and around the world.

In keeping with the Congress theme, *A Whole New World—International Collaboration creating Innovative Solutions*, AOPA is pleased to share the official list of congress partners

- U.S. National Member Society of the International Society for Prosthetics and Orthotics (USISPO)
- German Association of Orthopaedic Technology/Con.fair.med (sponsoring society for the biennial international O&P meeting in Leipzig)
- Amputee Coalition
- Canadian Association of Prosthetics and Orthotics (CAPO)
- Uniting Fronteras
- Mexico Member Society of ISPO



The World Congress will bring together prosthetists, orthotists, physicians, technicians, scientists, researchers, engineers, programmers, clinicians, pedorthists, fitters, physical therapists, manufacturers, suppliers and other rehabilitation care givers. This diverse community of professionals focusing on different aspects of orthotics and prosthetics will provide a unique and powerful environment to advance the field forward.

### ***What can AOPA members expect?***

The Best of the Best from the AOPA National Assembly will be integrated into the program—including the traditional AOPA Business education track. Don't miss four days of the best business education from AOPA staff, industry professionals and professors from the University of Virginia. Highlights include:

- RAC and Pre-payment Audits-- Everything You Need to Know --You can't afford to miss the latest updates on these draconian measures, spawned by massive upticks in audit activity to meet the Affordable Care Act budget targets -- how to fight these audits to the ALJ level, how to survive, comply and prosper in this cash-flow killing environment
- Business certificate programming sponsored by the University of Virginia
- The ever-popular Hamontree Lecture Series
- A case study highlighting four very different facilities to help you obtain optimum profitability
- FDA- What suppliers--domestic and international -- need to know about rules applicable to you. And how patient care facilities and central fabrication facilities may find themselves at risk
- A panel discussion to give you the real scoop on EHB, Audits, Obama Care and the Survival Imperatives
- Skills of the Past vs. Skills of the Future: Are We Ready to Change?
- Electronic Health Records
- Selling Your Business—Preparation and Valuation
- DME MAC Contractors will present a program on Audits
- Ask the Expert – AOPA staff experts' field more than 400 calls per month, assisting AOPA members with questions on coding, billing, audits, appeals, denials, documentation and more. Not surprisingly the most popular questions revolve around the topics of Documentation, Appeals, Audits and In-Patient Billing. Participate in a lively discussion and AOPA staff experts share information on these popular topics.
- Socialized Medicine and O&P Care – A Panel Discussion presented by representatives from around the world
- How to Really Use Social Media
- Food and Drug Administration (FDA), The Ins and Outs.

### ***Clinical Education***

When the planning committee announced the call for papers to the international community—they were hoping for a strong response, but were overwhelmed with more than 170 submissions from clinicians, researchers and other professionals from 24 different countries. In addition to strong abstract submissions, attendees will enjoy a plethora of Instructional Courses, Symposia, Workshops and a new Technical Laboratory where technical education will be presented styled after a cooking show type format. Watch your mail in the coming months as the preliminary program is released and the full program published.

### ***Exhibit Hall***

The 140,000+ gsf exhibit hall will take center stage as congress partners, manufacturers and suppliers from around the world present a trade show that is jam-packed with fresh ideas, the latest products and innovative solutions. The International Pavilion will showcase manufacturers and product from around the world.

### ***Not Your Ordinary Orlando Meeting***

In addition to premier scientific and business education by leading experts—you will have the opportunity to participate in an event like no other—a Special Event at Universal Studios on Friday, September 20. Luxury coach buses will transport you to Universal Studios for a memorable event as the park closes to the public. Special entertainment, refreshments and exclusive access to several memorable park attractions are all included in this optional event for World Congress attendees.

### ***Key International Speakers***

The planning committee has invited and confirmed the following Keynote speakers

- Jan Geertzen, MD, Ph.D., Immediate Past President of ISPO International
- Professor Yoshiyuki Sankai, World renowned inventor and speaker, recipient of many prestigious awards such as Japan Entrepreneur of the Year, World Technology Award and International Journal of Advanced Technology Best Paper Award.
- Roy D. Bloebaum, Ph.D. - is a Research Scientist and Co-Director of the VA Bone and Joint Research Lab at the Dept of Veterans Affairs (VA) Salt Lake City [Health Care System](#).
- Urs Schneider, MD, Ph.D.- is head of the Fraunhofer Orthopedics Research Department in Stuttgart. He is a medical doctor and leads a interdisciplinary engineering team with research focus on improved mobility solutions in rehabilitation and in orthopedic surgery.
- Heinz Trebbin, CPO, M.Sc - has been working in developing countries since his first experience in Tanzania in 1985. His area of expertise is the education of ortho-prosthetists and the clinical rehabilitation of people with disabilities. He gained experience with emergency aid projects through a 3-years assignment with the ICRC. He has developed extensive experience in the planning, implementation and evaluation of sustainable rehabilitation and education projects. He is currently working as an independent consultant and as a manger for DOI ortho-innovativ.
- Dan Berschinski – is a combat wounded double amputee and retired Army captain. He recently founded and serves as president of Two-Six Industries, LLC, a service-disabled veteran-owned small business. He also serves on the Board of Directors for the Amputee Coalition

**Watch your mail for the World Congress Preliminary Program to be among the first to learn the exciting developments of the World Congress Program.**

### **Membership**

#### ***Member Get a Member Campaign***

Of all the reasons that new members cite for joining AOPA, we hear most often that people joined because they were encouraged by colleagues in the industry. To show our appreciation for spreading the word about AOPA, we want to reward any employee of a member organization with a \$100 Visa gift card

for referring a friend. The new member will also get a \$100 Visa gift card, making it a great time to join AOPA. Just make sure your friend tells us they were referred by you, and we will get you both a gift card. Complete rules and online registration at [www.AOPAnet.org/MGM](http://www.AOPAnet.org/MGM)

## **Communications & Marketing**

### ***Educational Marketing***

Success in the marketing of AOPAversity audio conferencing, face-to-face learning experiences, and the various publications is reflected in the higher attendance, participation and publication orders by members. The Coding and Billing seminar continues to garner very positive feedback, with a blowout attendance of nearly 100 individuals in Atlanta. Attendance for the Audioconference Series in 2013 is surpassing ALL of last year's numbers!

### ***Online Communications***

Social media and websites have changed the ways that everyone does business. AOPA's [Facebook](https://www.facebook.com/americanoandp), <http://www.facebook.com/americanoandp>, and [twitter](https://twitter.com/americanoandp) accounts, <http://www.twitter.com/americanoandp>, are up approximately 30% in followers/likes. Members and those interested in the topics of the O&P community will find lively discussions, articles posted and sharing of general information. If your O&P practice is on [Facebook](https://www.facebook.com/americanoandp) and having difficulty finding topics to write about, the AOPA Facebook page is a great place to go to find the latest news tidbits, photos and things you can use for your office webpage. Also, don't forget to check the [AOPA homepage](http://www.AOPAnet.org), [www.AOPAnet.org](http://www.AOPAnet.org), for new events and breaking news!

### ***O&P Almanac***

The O&P Almanac continues to be a valuable resource for our members to find valuable articles, expert advice and other O&P resources such as job postings. The year started out strong with January's Issue covering "Lean" approaches to manufacturing & cost effective processes. Additionally, there was a featured article on how critical the roles of Orthotists and Prosthetists are in the nation's fight against diabetes.

February's issue covered the importance of early orthotic intervention for patients who have suffered from strokes to try and prevent and reduce long-term deformities. This edition also covered effective strategies on facility operations concerning how environmental impact and ethics can lead to boosts in business.

The highly praised March article titled, "Washington Watch", covered new and proposed policies and why it's important for O&P business owners to focus on cost-cutting and optimal patient care. The follow up feature discussed tumor treatments, limb salvage procedures, and amputation infusions concerning bone cancer diagnosis.

The most recent Almanac, April, reviewed the complexities of orthotists treating muscular dystrophy. The follow up feature story is a popular hit so far, "Help Wanted," an article identifying potential tactics for HR managers and O&P business owners to seek optimal candidates filling clinical and business positions. AOPA is increasing member awareness by publishing our job board material more often as a response to this article's popularity.

On the horizon, the May issue will cover "Continuing Education and O&P" and the 2013 AOPA Policy Forum Follow-up. The June issue will cover "Groundbreaking Research," a Superbug Update and feature the annual 2013 Buyer's Guide.

In 2013, we made a switch in digital information storage of the digital O&P Almanac from BlueToad to hosting by means of Issuu. A year's Issuu pro reader membership includes these benefits: Unlimited

Bandwidth, 15GB Storage, Analytics, Social Sharing Options, Library and Visual Customization, Extended embed options, and more. The annual rate paid for Issuu is less than the monthly costs with BlueToad. This is a significant improvement; resulting in cost-savings and increased benefits for our members.

### **And In Conclusion**

In closing, while the challenges facing the O&P profession are daunting, and sometimes even exasperating, it is important to recognize that every supportive effort from our members counts. Recently, we issued a call to arms to encourage members to send a request to their Congress member asking the member to sign-on to a letter to Secretary Sebelius addressing the RAC audit concerns that face our industry. The response to that campaign by AOPA members was tremendous. The O&P community sent over 1,700 messages to over 375 members of Congress requesting their sign-on. Thank you for taking the time out of your busy schedules to participate! Every letter you send, every follow-up call to your legislator, these actions all contribute to a greater cumulative impact on the issues we are facing. Please continue to join together and support AOPA as we push forward on these critical issues.

Sincerely,



Thomas F. Fise, JD  
Executive Director

PS. On January 1, 2013 nearly all sellers of medical devices became subject to a 2.3 percent excise tax - **THAT IS EVERY ONE BUT** folks like you who sell O&P medical devices plus a few others that qualify for the "retail exemption." AOPA's effort to secure this exemption for you was made possible by your support and that support makes possible the nearly \$100 million in savings each year for the O&P community and their patients!



**Congress of the United States**  
**Washington, DC 20515**

April 15, 2013

The Honorable Kathleen Sebelius  
Secretary, US Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

CC: Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services

Dear Secretary Sebelius,

We are writing because of our concern that efforts to reduce fraud and abuse in Medicare claims for prosthetics may be harming access to care for the most vulnerable Medicare beneficiaries.

We strongly support efforts to combat fraudulent payments. According to the GAO, for Fiscal Year 2011, the estimated improper payments within Medicare cost approximately \$65 billion. Finding and stopping these fraudulent payments is a critical task, however, we are seriously concerned about the unintended consequences of current efforts that may reduce patient access to care and harm upstanding small businesses. It has been brought to our attention that audits conducted by the Centers for Medicare and Medicaid Services (CMS) contractors concerning claims for prosthetics are jeopardizing the economic viability of these critical health care providers.

As we see it there are two issues. The first is challenges to physician documentation for prosthetics. Auditors are now using a standard that CMS contractors, without the benefit of any rulemaking processes, generated in an August 2011 "Dear Physician" letter that is based on a flawed 2011 Office of Inspector General Report. Second, according to the industry, the number and scope of audits are continuing to increase dramatically. Furthermore, these claims are being appealed, with some adverse decisions by CMS contractor auditors being overturned at the administrative law judge (ALJ) level.

Consequently, CMS's current policies are resulting in contractor audits challenging legitimate payments for prosthetic care to the degree that these critical health providers are facing terminal cash flow deficiencies. In addition to jeopardizing the jobs and economic growth added by providers of orthotic and prosthetic devices and services, many of which are small businesses, the inability of these providers to serve patients, including vulnerable Medicare beneficiaries, creates an unnecessary barrier to access.

The American Orthotic and Prosthetic Association (AOPA), representing facilities that provide orthotic and prosthetic services, recently completed a survey of its members' encounters with such audits. The survey found that 77 percent of AOPA's facilities have been subject to one or more recovery audit contractor (RAC) audits relating to physician documentation, with many facilities having been subjected to more than 20 such audits in the 11 months preceding the survey. At the facility level, these and other similar audits have led to many small businesses being stretched to their breaking points financially, hindering economic growth and costing

precious jobs. Taken collectively, the strain on the industry undermines critical patient access to orthotic and prosthetic services.

It is imperative that we find a way to develop policies that allow CMS to eliminate true fraud and abuse, while not slowing payment to providers so significantly that they cannot function. We believe it is possible to strike a reasonable balance that would ensure effective scrutiny and protection of taxpayer dollars while still preserving the viability of crucial orthotic and prosthetic specialists.


We understand it is not CMS' intent to harm these facilities. CMS leadership has also acknowledged significant deficiencies with the physician documentation standard (from the "Dear Physician" letter) that CMS contractors apply, frequently retroactively, to claims from before that standard was articulated. However, given that this has been the effect of anti-fraud activities, we respectfully request clarification on a few areas of concern for orthotic and prosthetic suppliers. Please respond to the following questions in writing.

- What specifically is CMS' policy to ensure that anti-fraud activities, while necessarily rigorous, do not place undue and/or counterproductive burdens on providers?
- Does CMS believe that implementing regulations pursuant to the Benefits Improvement Protection Act of 2000 (BIPA), Transmittal 656, or other measures, including legislation, could aid in ensuring that only licensed and/or accredited providers be eligible for Medicare reimbursement, thereby reducing instances of fraud and the need for overly burdensome "pay and chase" activities?
- Given the growing number and scope of audits, and the confusion over standards that providers are subject to, are there interim steps CMS could take to maintain program integrity while not restricting provider cash flow so severely?
- In some instances, after delivery of an orthotic or prosthetic device, auditors may disagree with a single line-item amongst an otherwise wholly appropriate course of treatment, resulting in a provider's payment being entirely withheld. Would it be possible for CMS to withhold reimbursement for the specific codes or components of an artificial limb that CMS' auditors believe is inappropriate, instead of denying payment for the entire limb or service?
- Can you provide information documenting the rate at which ALJ decisions ultimately result in auditor payment denials being reversed, both in number and as a percentage of total appeals, also noting at what stage of appeal the final decision was made?

If you have any questions, please do not hesitate to contact Kalina Bakalov in the office Representative Tammy Duckworth at 202-225-3711, or Megan Spindel in the office of Representative Brett Guthrie at 202-225-3501.

Sincerely,


  
Tammy Duckworth (IL-08)  
MEMBER OF CONGRESS

  
Brett Guthrie (KY-02)  
MEMBER OF CONGRESS



  
Aaron Schock (IL-18)  
MEMBER OF CONGRESS

  
Billy Long (MO-07)  
MEMBER OF CONGRESS


  
James P. Moran (VA-08)  
MEMBER OF CONGRESS


  
David Phillip "Phil" Roe (TN-01)  
MEMBER OF CONGRESS

  
Robert E. Latta (OH-05)  
MEMBER OF CONGRESS

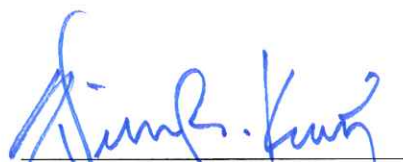
  
Danny K. Davis (IL-07)  
MEMBER OF CONGRESS


  
Todd Rokita (IN-04)  
MEMBER OF CONGRESS

  
Bill Johnson (OH-06)  
MEMBER OF CONGRESS

  
Mark Pocan (WI-02)  
MEMBER OF CONGRESS

  
Daniel B. Maffei (NY-24)  
MEMBER OF CONGRESS

  
William R. Keating (MA-09)  
MEMBER OF CONGRESS

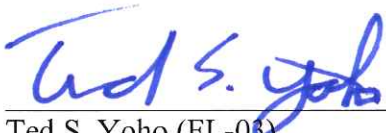
  
Lee Terry (NE-02)  
MEMBER OF CONGRESS



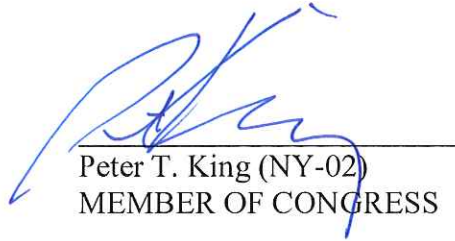
Eric Swalwell (CA-15)  
MEMBER OF CONGRESS



Carol Shea-Porter (NH-01)  
MEMBER OF CONGRESS



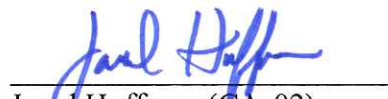
Ted S. Yoho (FL-05)  
MEMBER OF CONGRESS



Peter T. King (NY-02)  
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Mike Quigley (IL-05)  
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Jared Huffman (CA-02)  
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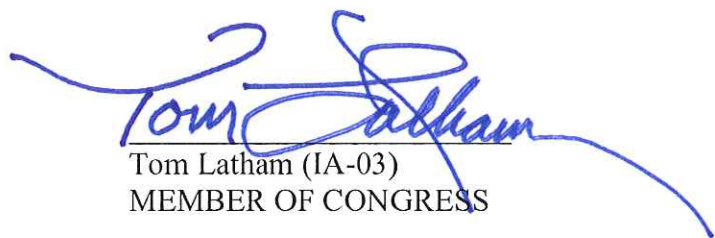
Chellie Pingree (ME-01)  
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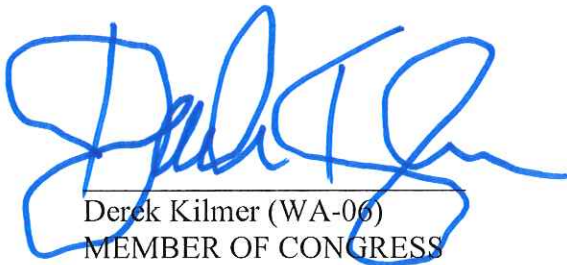
Corrine Brown (FL-05)  
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Sam Graves (MO-06)  
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Tom Latham (IA-03)  
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Derek Kilmer (WA-06)  
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Bruce L. Braley (IA-01)  
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Michele Bachmann (MN-06)  
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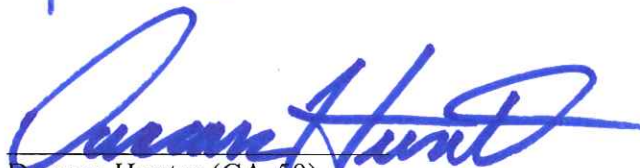
  
Nick J. Rahall, II (WV-03)  
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Duncan Hunter (CA-50)  
MEMBER OF CONGRESS

  
C.A. Dutch Ruppersberger (MD-02)  
MEMBER OF CONGRESS

**THOMAS L. MILLS**  
Partner  
202-282-5714  
Tmills@winston.com

April 15, 2013

**VIA FEDERAL EXPRESS & EMAIL**

Kathleen Sebelius  
Secretary  
Department of Health & Human Services  
200 Independence Ave., S.W.  
Washington, D.C. 20201

Marilyn Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Mail Stop 314G  
200 Independence Ave., S.W.  
Washington, D.C. 20201

**Re: American Orthotic & Prosthetic Association**

Dear Secretary Sebelius and Administrator Tavenner:

I write on behalf of the American Orthotic & Prosthetic Association (AOPA) to supplement my December 14, 2012 letter to Marilyn Tavenner regarding unlawful conditions imposed by CMS on claims for prosthetic devices.

As explained in the December 14 letter, CMS MACs improperly issued an August 2011 "Dear Physician" letter that requires physicians to make and document K-level determinations on the rehabilitation potential of amputees. Typically an amputee's physician is either the surgeon who performed the amputation or the amputee's general physician, neither of whom is trained to make assessments of the patient's functional capabilities, to grade those capabilities on a K-0 to K-4 scale, or to evaluate how those capabilities could be improved by an artificial limb. In recognition of this reality, CMS previously paid claims where the prosthetist prepared K-level assessments and work orders that the physician endorsed.

However, CMS altered this standard with the "Dear Physician" letter and now requires documentation to be completed by the physician. CMS further is limiting what constitutes the medical record supporting the medical necessity of a prescribed

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WASHINGTON, D.C.

prosthetic device. The "Dear Physician" letter states that "it is the treating physician's records, not the prosthetists', which are used to justify payment." In recent correspondence, CMS has repeated that "Medicare looks to the documentation *in the treating physician's records* as the primary source of information to support that the item or service is reasonable and necessary." However, medical necessity is based on the patient's entire record, not just the records of the physician. Indeed, CMS' Program Integrity Manual says as much: "The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other health care professionals." Medicare Program Integrity Manual, § 5.7. Medicare historically has viewed prosthetists as health care professionals. Not only does Medicare pay for their services, but an earlier version of § 5.7 of the Manual defined "other health care professionals" as including, but not limited to nurses, physical or occupational therapists, *prosthetists*, and orthotists." In short, CMS' own Manual recognizes that prosthetist records are entitled to the same deference as physician records.

CMS' justification for now ignoring its own Manual and refusing to treat prosthetists' notes as part of the medical record is that prosthetists may have a "vested financial interest in the outcome of the claim decision." This justification is ironic, given the vested financial interest CMS contractors have in disallowing the claims they are hired to review. Moreover, CMS cannot point to any statutory authority allowing it to disregard the judgment of prosthetists merely because CMS believes that a possibility exists that their judgment may be tainted by self-interest. As AOPA has pointed out, there are scores of situations in which physicians make judgments that arguably could be affected by self-interest, yet CMS does not challenge those judgments.

In addition, in situations in which Congress believes that provider self-interest adversely impacts care rendered to Medicare patients, it has acted to rectify that self-interest. Indeed, Congress has addressed perceived waste and abuse in connection with the provision of artificial limbs not by insisting that physicians rather than prosthetists document the need for such limbs, but rather by requiring that prosthetists be certified. Specifically, Congress included in Section 427(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA") a prohibition on Medicare payments for prosthetics and custom-fabricated orthotics unless the devices were (1) furnished by a qualified practitioner and (2) fabricated by a qualified practitioner or supplier. Congress defined a "qualified practitioner" as a (a) qualified physical therapist or occupational therapist, (b) an individual licensed in prosthetics or orthotics in the state in which the prosthetic or orthotic device is supplied, or (c) in states lacking licensing, an individual certified by the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification, or under an equivalent program. Congress defined a "qualified supplier" as an entity that is accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification or under an equivalent program.

Section 427(b) of BIPA directed the Secretary to promulgate regulations to carry out the qualification requirements of Section 427(a). Congress directed that the regulations be promulgated no later than one year after enactment of BIPA. The one-year anniversary of BIPA was December 21, 2001.



Over 11 years later, CMS still has not promulgated regulations to implement Section 427(a) of BIPA, even after the OIG brought this failure to CMS' attention in an October 2012 report.

Nowhere did BIPA or any another statute give the Secretary the authority to deter waste and abuse by insisting that only physician records, rather than the entire medical record including prosthetist notes, could establish medical necessity for prosthetic devices. Putting aside the lack of statutory authority for CMS to ignore certification requirements and to instead impose a physician documentation standard via the "Dear Physician" letter, CMS failed to act in accordance with rulemaking statutes. CMS did not promulgate the "Dear Physician" letter's change in documentation standards for claims for artificial limbs through a rulemaking process as required by the Administrative Procedure Act and Section 1871(a)(2) of the Medicare Act, 42 U.S.C. § 1395hh(a)(2). Similarly, CMS' requirement, embodied in the "Dear Physician" letter, that physicians assess the patient's K-level was not imposed through a rulemaking process. Notably, CMS has recognized in analogous situations the need to proceed through a formal rulemaking, with the public given notice and an opportunity to comment on the proposed regulations. *See* 71 Fed. Reg. 17021 (April 5, 2006) (promulgating regulations on documentation for claims for mechanized wheelchairs).

The change in documentation requirements also has been applied retroactively, in violation of both the APA and Medicare Act. CMS contractors continue to audit AOPA members and to deny coverage on claims that were submitted before the "Dear Physician" letter was published in August 2011.

CMS contractors also are becoming more aggressive in rejecting claims based on a perceived lack of physician documentation. AOPA members are being subjected to both audits of previously-paid claims and pre-payment audits by CMS contractors. In both cases, CMS contractors are relying on the "Dear Physician" letter in denying the claim, claiming that there is insufficient documentation from physicians to justify the prosthesis device that was prescribed. Often the contractors fail to identify what documentation they believe is missing, thereby denying suppliers the opportunity to cure the alleged omission. Contractors further frequently fail to identify the rationale for their conclusions.

Even worse, the CMS contractors are denying the claim in full, even in situations in which there is no dispute as to the amputee's need for a prosthetic. In those cases, the debate is over how sophisticated a prosthetic device the patient needs to function, rather than whether the patient has a medical need for a prosthesis at all. CMS accordingly has no justification for not at least paying an amount equal to the cost of a lesser-cost prosthesis. However, CMS contractors have a financial incentive to disallow the claim in full, since they are paid based on the dollar amount of the disallowance. The American Hospital Association evidently is in litigation with CMS over similar conduct by CMS contractors.

Aside from failing to rein in its contractors, we also note that CMS is improperly putting the onus for compliance on prosthetists and suppliers, rather than on physicians. The statute on which CMS relies to justify the "Dear Physician" letter, Section 1842(p)(4) of the Medicare Act, 42 U.S.C. § 1395u(p)(4), provides that if the Secretary requires documentation from a physician as a condition of a supplier receiving payment for an artificial limb ordered by the physician, *the physician must* provide that

documentation to the supplier at the time he or she issues the order. However, we are unaware of any physicians who have been sanctioned for supplying documentation later alleged to be inadequate. Moreover, CMS contractors are not even looking to the physicians to provide the allegedly lacking documentation. Instead, CMS contractors are refusing to process supplier claims, or are seeking refunds from suppliers for earlier-paid claims, in cases where they allege that physician documentation is deficient. Prosthetists thus are being forced to suffer extreme financial consequences because of the *physician's* failure to honor the *physician's* statutory duty.

We understand the need to prevent waste, fraud, and abuse in the dispensing of prosthetic devices. However, CMS is avoiding the means Congress directed of achieving that goal, in favor of implementing new rules that pose undue burdens on Medicare patients and suppliers. We urge you to correct this situation immediately by withdrawing the "Dear Physician" letter, by instructing CMS contractors to treat prosthetist notes as part of the medical record, and by insisting that CMS contractors explain in detail the basis for any disallowance of claims for prosthetic devices. Given the extreme financial difficulties confronting many AOPA members because of the actions of CMS contractors, we request a response by April 29.

Sincerely,



Thomas L. Mills  
Attorney for AOPA

cc: George G. Mills, Director  
Provider Compliance Group, Office of Financial Management,  
Centers for Medicare & Medicaid Services





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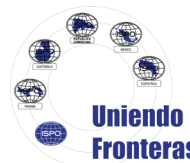
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