American Orthotic & Prosthetic Association

Restore Due Process Rights & Proper Administrative Law Judge Timeframes

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Other Strengthening Orthotics & Prosthetics in Medicare Measures

* Recognize Orthotist's & Prosthetist's Notes

*Separation of Orthotics & Prosthetics from Durable Medical Equipment

Background

There are five levels in the Medicare claims appeal process and the Administrative Law Judge (ALJ) is the third level; and the Office of Medicare Hearings and Appeals (OMHA) is the entity responsible for overseeing the ALJs. The ALJ level allows a supplier/beneficiary/provider the opportunity to present their appeal to a person who will independently review the materials provided and render a new decision in accordance with the law and not render a decision based on Medicare policy; and according to the HHS-OIG, ALJs reversed prior-level decisions and decided fully in favor of appellants in 56 percent of appeals in FY 2010. The recent Cromnibus Bill also stated that: "Information received from the Office of Medicare Hearings and Appeals (OMHA) indicates that about 50 percent of the estimated 43,000 appeals were fully or partially overturned at its level".

Current ALJ/OMHA Statistics

- In January 2012 the weekly average of requests for appeals filed was 1,250. In December 2013 the weekly average rose to 15,000
- In December 2013 the OMHA estimated the backlog of pending appeals grew from 92,000 claims to over 460,000 claims; and it was estimated to reach nearly 1,000,000 by the end of 2014
- Requests for ALJ hearings in fiscal year 2011 totaled 59,600. In fiscal year 2013 the total was 384,151 and in fiscal year (through June) 2014 the total was 395,000. At present, there are approximately 1 million claim appeals awaiting an ALJ hearing and decision
- In FY14 (as of June) 227,000 appeals filed with the ALJs were the result of RAC audits
- The number of appeals decided by an ALJ in fiscal year 2011 was 53,868 in fiscal year 2013 the number was 79,372 and in fiscal year (through June) 2014 the total was 87,266

- OMHA anticipates that assignment of requests for ALJ hearings may be delayed for up to 24 months
- As of October 2014 OMHA was still assigning appeals from 2013.
- Average processing time for an appeal decided by an ALJ in fiscal year 2015 is 547 days, compared to 94.9 days in fiscal year 2009; 121.3 days in fiscal year 2011, 220.7 days in fiscal year 2013 and 414.8 days in fiscal year 2014

This increased workload, number of appeals being filed, and the backlog being created is directly related to the increase in audit activity by Medicare and its contractors over the last few years. In an attempt to work through the backlog the OMHA has temporarily suspended the assignment of any new ALJ hearing requests as to claims appeals by providers (no interruption in assigning patient/beneficiary claims) and anticipates that assignment of requests for ALJ hearings may be delayed for up to 24 months, in essence halting the appeal process for up to two years. Before OMHA enacted the temporary suspension in assigning hearing dates for new appeals, O&P providers have already been forced to wait up to 26 months to get their appeal heard by the ALJ. This suspension will almost certainly make the wait even longer (perhaps 4 years or longer), in violation of the law which stipulates that a provider is entitled to an ALJ decision within 90 days of the date the provider files an appeals.

However, this temporary delay doesn't halt all aspect of the audit process or provide any solace or break to suppliers/providers. During this two year delay any money CMS previously paid on claims, now denied through audits, is being recouped, with interest, and held by Medicare until the appeals process is completed. Other Medicare providers have been offered an opportunity to enter into negations to receive a prompt and equitable settlement, to alleviate their financial burdens and receive a partial payment; however these types of arraignments have not been extended to O&P providers.

So, even though CMS through the OMHA has halted the appeals process they have not halted their collection activities. Also as this temporary delay drags on the audit appeals are continuing to pour in causing the supplier/provider to file more appeals; increasing the ALJ backlog and placing an even greater finical burden on the healthcare provider.

A contributing factor to the rise in ALJ requests and the subsequent backlog is a result of increased audit activity, both pre-payment and post payment, by Medicare contractors. These 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.

This focus on physician documentation as the determining need for medical necessity was a shift in Medicare policy and was the result of a flawed 2011 Office of Inspector General (OIG) 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. Prior to the 2011, Medicare relied on the patient evaluating notes of the orthotist and prosthetist to determine the medical necessity of the type of orthoses or prostheses required by the patient.

Recommendation

Congress emphasized the importance of quickly processing Medicare appeals when it passed the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), which included a statutory requirement that ALJ's issue decisions no more than 90 days from the date the appeal request filing date.

CMS/OMHA continues to exceed the timeframe established by the SCHIP statute and leaves Medicare providers without an adequate avenue of redress against CMS and its contracted auditors' (many of whom are compensated on a 'bounty' system) over payment denials of individual claims. Moreover, the growing backlog in provider appeals continues to put financial pressure on providers, many of whom operate small businesses that cannot afford to have cash flows endlessly held up in the appeal process.

Please communicate to acting CMS Administrator Slavitt that CMS/OMHA continue to violate their statutory requirement for an ALJ hearing within 90 days, and compel them to suspend any new audits, including any overpayment recoupments until such time as CMS/HHS/OMHA can demonstrate that they are complying with the 90-day statutory time frame for an ALJ decision. Also, please show your support by cosponsoring the Medicare Orthotic & Prosthetic Improvement Act of 2015, The Hospitals Improvements Payment Reform Act and other pieces of legislation being introduced in Congress which aim to restore due process to providers and help eliminate the current ALJ backlog.

The noted Medicare research firm, Dobson-DaVanzo, has developed a preliminary CBO-type analysis, based on the actual claims experience—both from OMHA and over 100 random, sequential Medicare claims histories from prosthetic & orthotic providers—which demonstrates that shifting the recoupment for audit claims until AFTER the ALJ hearing would actually save money for the Medicare program! Dobson-DaVanzo presented these results in a news advisory conference call on Thursday, March 19. You may access the streaming audio of the call at www.aopanet.org. Sparing small business providers, who until now have been forced to pay the government in advance on audits, from the threat of bankruptcy as they wait years for an ALJ hearing AND saving the Medicare program money is the right solution!

Please consider becoming a cosponsor on legislation being introduced by Rep. Meadows (R-N), The Strengthening of Orthotics & Prosthetics in Medicare Act, this legislation would re-establish the clinical notes of the treating orthotic or prosthetic practitioner as part of the patient's medical record and subsequently are sufficient enough to determine the medical necessity of the proper orthotic and prosthetic (O&P) care. The re-re-establishment of the legitimacy and validity of the orthotist's and prosthetist's notes would eliminate a large number of claims that are currently being incorrectly denied due to lack of notes in the medical record, and help alleviate the backlog of appeals facing the ALJs. The validity of the orthotist's and prosthetist's notes is further enhance by separating orthotics and prosthetics from durable medical equipment(DME),

and this is also accomplished by the Strengthening of Orthotics & Prosthetics Act. Currently, in the eyes of Medicare regulations O&P providers are lumped in with DME suppliers. However, O&P providers must obtain a Master's degree, complete a residency program and become certified before they may begin providing care. These rigorous requirements allow them to provide the level of care, including the ability to thoroughly document medical necessity, needed to treat patients with limb loss and limb impairment; instead of simply dispensing an item to a patient and never seeing that patient again.

Your support will both save the government money and will keep small business providers out of bankruptcy.

Justice Delayed is Justice Denied

For more information contact the American Orthotic & Prosthetic

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