

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 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.

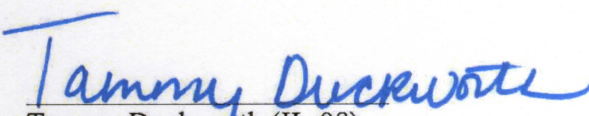
It is imperative that we find a way to develop policies that allow CMS to eliminate true fraud and abuse, while not slowing payment to providers so significantly that they cannot function. We believe it is possible to strike a reasonable balance that would ensure effective scrutiny and protection of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

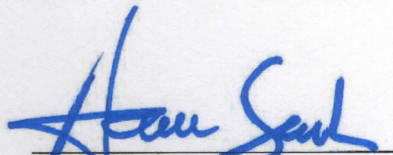
- What specifically is CMS' policy to ensure that anti-fraud activities, while necessarily rigorous, do not place undue and/or counterproductive burdens on providers?
- Does CMS believe that implementing regulations pursuant to the Benefits Improvement Protection Act of 2000 (BIPA), Transmittal 656, 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?

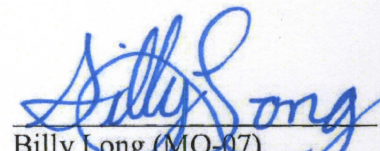
If you have any questions, please do not hesitate to contact Kalina Bakalov in the office Representative Tammy Duckworth at 202-225-3711, or Megan Spindel in the office of Representative Brett Guthrie at 202-225-3501.

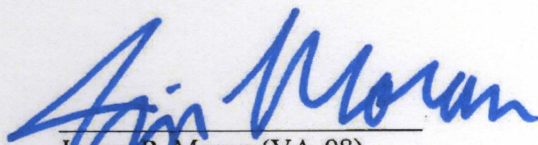
Sincerely,

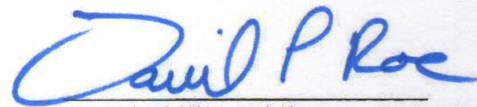

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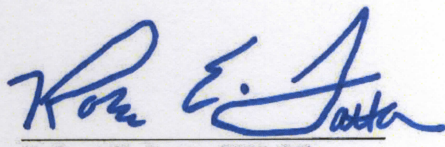

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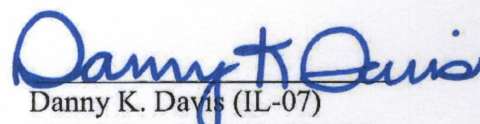

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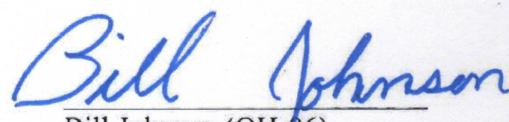

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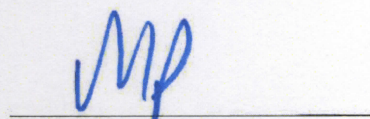

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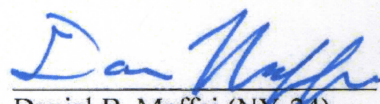

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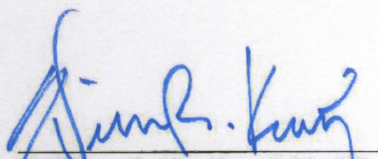

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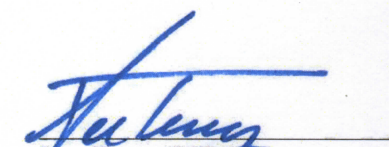

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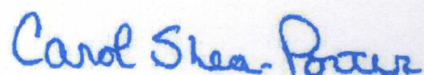

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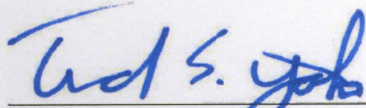

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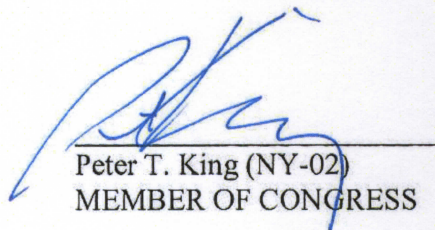
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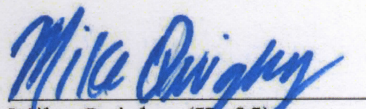
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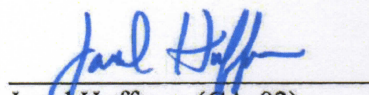
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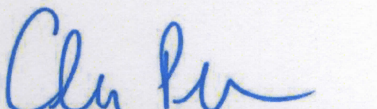
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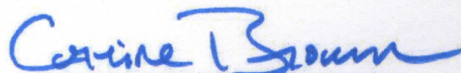
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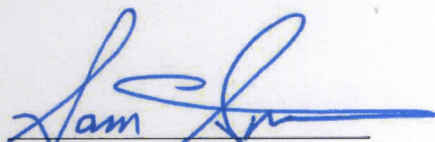
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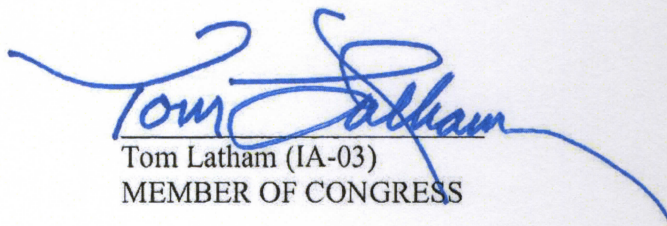
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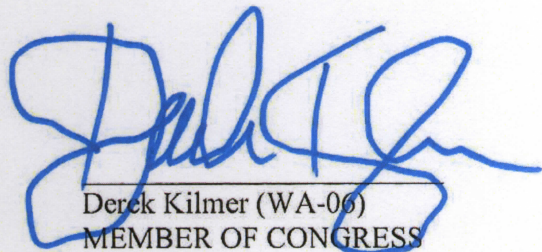
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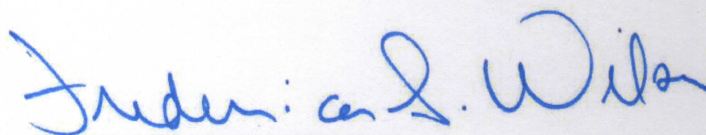
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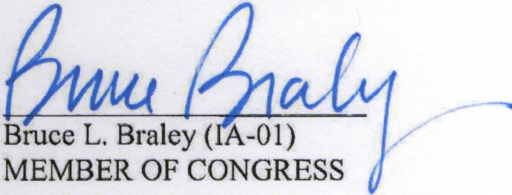
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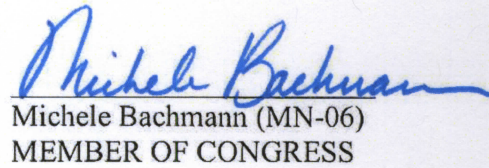


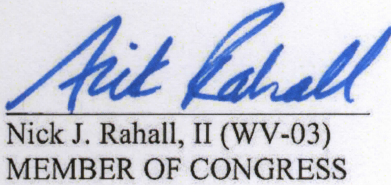
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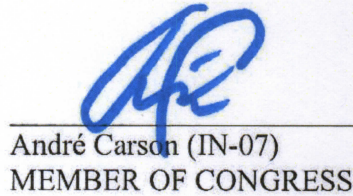


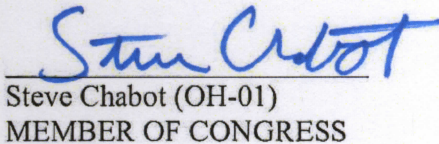
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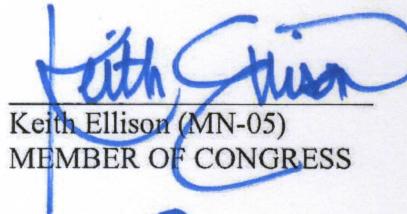

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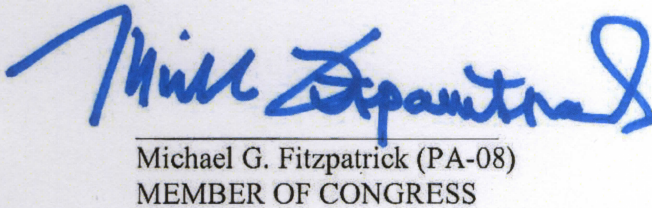

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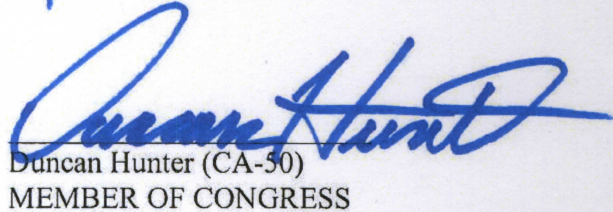

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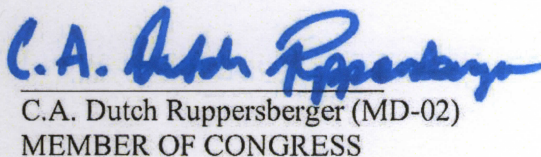

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