A TOPIC AOPA IS WORKING ON THAT IS IMPORTANT TO THE FUTURE OF YOUR BUSINESS

WHY Prior Authorization as CMS Has Proposed It, Is Neither AN ANSWER NOR AN ALTERNATIVE for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The Core of the Issue

The BIG hitch with prior authorization is that it is NOT a promise to pay. It is only a "provisional affirmation" (approval) or preliminary finding that a future claim meets Medicare's coverage, coding and payment rules. Claims receiving this provisional affirmation may still be denied, for example based on a variety of requirements such as finding the claim is a duplicate, that the patient has died, or that the claim has improper proof of delivery. Tempting as it is to think anything has to be better than what we have or to embrace the 'concept' of prior authorization without looking at the details of CMS's plans, AOPA and the vast majority of its patient care facility members oppose pre-authorization as a 'solution' to RAC and other audits. It simply doesn't solve the problem.

Medicare Prior Authorization would be in addition to, not in place of RAC and pre-payment audits. The proposal makes no promise to stop or reduce audits; rather it lays another regulatory level on top of audits!

CMS has proposed this new rule referencing an ongoing demonstration project involving prior authorization on Power Mobility Equipment (power wheelchairs) and its intention to expand its authority both by increasing the number of states in the DME Power Mobility Equipment project, as well as to implement a prior authorization process for additional DMEPOS items, most notably prosthetics, immediately on a nationwide basis (no demo in a few states for prosthetics) that are frequently subject to unnecessary utilization or a high improper payment rate as established by the Office of the Inspector General or error rates reported by the Comprehensive Error Rate Testing (CERT) contractors. Those items must have an average purchase fee of $1,000 or greater or an average rental fee schedule of $100 or greater per month.

That's scary. This whole proposal is based on the CMS experiment with power wheelchairs which are provided without any clinical care or expertise nor the nuanced and clinical expertise so power wheelchairs have virtually nothing in common with a prosthetic intervention. Yet the proposed rule includes a "Master List" of 89 lower limb prosthetic codes that CMS believes should be subject to prior authorization. Under the proposed rule CMS could initially select a sub set (or all) of the "Master List" items for prior authorization that would be published in the Federal Register with a 60 day comment period. CMS promises "reasonable efforts" to communicate a "provisional affirmation" decision within 10 days of receiving all applicable information but reports from the field indicate the power mobility project wait time is often longer. With a more complicated lower limb claim, how can CMS fulfill a 10 day turnaround promise?

Why Is It Important To You?

This proposal is not only important to you, it is extremely important to our patients and represents another example of trying to get CMS to understand that the clinical care and expertise in providing prosthetics is a far cry from any expertise needed to ship power wheelchairs and other DME items. Some of the L codes are for components needed to make a customized device. What happens if one or more components do not receive the "provisional affirmation?" What happens to patient wait times? Are patients to remain in a wheelchair while multiple prior authorization requests channel through the CMS process? What happens to residual limb preparation or healing if decisions take longer than 10 days? This additional layer will not solve or relieve the RAC audit issues. Claims will still be subject to further audits of any type under the proposed rule. It's important to understand that preauthorization is not a panacea for the challenges faced by the O&P community but is likely another impediment to providing timely care and operating an efficient patient care facility.

> **"We need EVERY AOPA member and a substantial number of prosthetic patients to submit comments so CMS recognizes the very significant changes that would be required to make this proposal deserving of bona fide consideration."**

What Is AOPA Doing About This?

AOPA notified members May 23, 2014 of the pending proposal and provided links to the proposed regulations urging members to file their own comments within the 60 day comment period commencing May 28, 2014 with comments due no later than July 28, 2014.

To facilitate AOPA's own comments, President Liberman-Lampear has appointed a five person task force to work with staff in developing our response. But our AOPA comments are not enough—we need EVERY AOPA member and a substantial number of prosthetic patients to submit comments so CMS recognizes the very significant changes that would be required to make this proposal deserving of bona fide consideration.

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AOPA's comments will be shared with the entire AOPA membership ASAP so there can be some consistency in the O&P community's response to the proposed rule.

AOPA has fanned out to do roughly 30 meetings on the Hill to inform Members of Congress and their staff of the dire consequences that may be generated by the proposed pre-authorization process. Key staffers on both the Senate and House side initiated contacts with me within 48 hours of the announcement. These initial conversations with top health staffers outlined our need to have a specific caregiver exception applicable to physicians, therapists and O&P providers. There needs to be recognition that O&P providers are licensed or certified clinicians, unlike DME providers. If pre-authorization is imposed then there has to be a guarantee of payment so the timeliness of patient care is not disrupted and RAC audits must be suspended on claims "provisionally affirmed."

AOPAVotes has a model letter for you to send to CMS outlining your own opposition and concerns over patient care plus how it will create even more confusion in the marketplace. AOPA members will receive a packet of postcards for distribution, signing and mailing (postage paid) by patients, the folks with a huge stake in this process. Here are the key shortcomings in the CMS proposal that need to be remedied if the proposal is to be part of the solution instead of adding to the problem:

1. Prior Authorization Must Constitute a Guarantee of Medicare Payment
Prior authorization needs to constitute a guarantee of Medicare payment. Elimination of Part B RAC and prepayment audits must be the quid pro quo for instituting prior authorization. Requiring providers to undergo prior authorization and then subsequently deny a claim defeats the purpose of prior authorization.

2. RAC Audits Should Cease Immediately Once Prior Authorization Regulations Are Issued in Final Form
Once prior authorization regulations are announced as a final rule, RAC audits and prepayment audits of claims across ALL categories of providers must cease immediately.

3. There Should Be a Threshold for Items to Be Subject to Prior Authorization
The current proposed threshold of $1,000 is no threshold at all, as it would encompass (and thus subject to prior authorization) every prosthetic limb. Prior authorization should only apply to items that are over a threshold of 167 percent of the average total per patient prosthetic claim by Medicare data for last available year and inflation adjusted to become the current year. Additionally there must be exclusion for any immediate post surgical and/or preparatory prostheses.

4. There Must Be Certainty in the Prior Authorization Process
As seen in the Power Mobility Devices prior authorization demonstration, CMS has five days to approve or to deny with an explanation. In order to ensure that a decision is made in a timely manner, if a decision has not been made in five days accompanied by specific reference and details of the specific beneficiary (no blanket disapprovals as a matter of CMS delay and convenience), the prior authorization request should be deemed approved and final, so that patient care may proceed.

5. CMS Must Acknowledge that the Prosthetist's Notes and Records on Patient Visits ARE a Legitimate part of the Medical Record, on the same basis as those of the physician, therapist or other licensed and/or accredited health care provider.
The prosthetist's clinical documentation specifically functional assessment as it translates into appropriate prosthetic design and component selection are the foundation of his/her education and training. This skill set is unique to prosthetists among all other providers identified as "qualified" in BIPA 427.

This is your chance to make sure this goes in the right direction.

The Bottom Line

This has been quite a year. We can't get through it and survive unless we band together as one voice on this pre-authorization issue and continue to fight the disruption caused by the overzealous RAC auditors. We all must resist the assault on your due process rights by virtue of the incredible 26 month or more delay in appeal to the Administrative Law Judge.

In closing, as of this writing the government's motion to dismiss AOPA's lawsuit against CMS because of its failure, among other things, to observe the Administrative Procedure Act has not been ruled upon by Judge Lamberth. A favorable development was a higher court's refusal to grant the government's motion to dismiss in a somewhat similar case to AOPA's which is encouraging. Your support has made the litigation possible as well as pursuing the other battles we have fought this year. AOPA has done, and is doing EVERYTHING possible to try to find a resolution, some relief from the audit crescendo for prosthetics. Much as we wish CMS's proposal for prior authorization could help solve the RAC/Pre-payment audit Armageddon, their current proposal is not ready, in its current form, for prime time, and hence we must vigorously focus this opposition in comments to the proposal. Just one more reminder to please make sure your colleagues are part of this AOPA team. We're doing everything humanly possible to preserve patient care and your future.

Very truly yours,

Thomas F. Fise, JD
AOPA Executive Director