THE ORTHOTIC AND PROSTHETIC ALLIANCE

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RE: **Office of Inspector General Report, "CGS Administrators, LLC, Paid Unallowable Lower Limb Prosthetic Claims" (A-06-12-00055);**

OIG Report, "Durable Medical Equipment Claims Paid by National Heritage Insurance Company, Inc. Did Not Always Meet the Requirements of the Local Coverage Determination for Lower Limb Prostheses" (A-07-13-05040);

OIG Report, "Durable Medical Equipment Claims Paid by Noridian Healthcare Solutions, LLC, Did Not Always Meet the Requirements of the Local Coverage Determination for Lower Limb Prostheses" (A-07-12-05035);

OIG Report, "National Government Services, Inc. Paid Unallowable Lower Limb Prosthetics Claims" (A-07-13-05039)

Dear Ms. Jarmon and Mr. Cogley:

On behalf of the Orthotic & Prosthetic Alliance (the O&P Alliance), a coalition of the five major national orthotic and prosthetic organizations representing over 13,000 O&P professionals and 3,575 accredited O&P facilities, we are writing to address the findings contained in the four recent OIG reports referenced above.

The O&P Alliance commends the OIG's efforts to hold Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) accountable for implementing appropriate edits to ensure proper payment of Medicare claims. As you may recall, the reports referenced above found that CGS, NHIC, Noridian Administrators and National Government Services collectively paid $8,030,106 in claims for lower limb prostheses that are alleged to have failed to meet local coverage determination (LCD) requirements. For a number of these claims, the OIG found that the MACs did not implement the proper claims processing edits to effectuate the LCD requirements.

However, we wish to outline additional steps that the Centers for Medicare and Medicaid Services (CMS) should take to further curtail payment of inappropriate claims. Specifically, we request that the OIG reiterate that CMS has failed to implement claims edits related to qualified practitioners and suppliers of custom orthotics and prosthetics that were mandated by Section 427 of the Beneficiary Improvements and Protection Act of 2000 (BIPA). OIG should insist that CMS finally implement this federal law as a necessary and immediate step in curtailing overpayments for custom orthotics and prosthetics from unqualified providers and suppliers.

We have consistently encouraged CMS to implement these provisions since their enactment into law 13 years ago and the results of each of these four OIG audits reflects CMS' failure to do so. In fact, linking practitioner and supplier qualifications to the ability to bill Medicare for custom orthotics and prosthetics was originally conceived by the OIG itself. This policy dates back to 1997, when OIG issued a report entitled, *Medicare Orthotics* (OEI-02-95-00380) and subsequently, in March 2000, *Medicare Payments for Orthotics; Inappropriate Payments* (OEI-02-99-00120).

In these reports, the OIG recommended repeatedly that CMS (then HCFA) adopt supplier standards for those who provide custom orthotic and prosthetic services and devices, and CMS agreed with these recommendations. As a result, Congress adopted statutory language that became BIPA, Section 427. This federal law limited the ability to bill the Medicare program for custom orthotics and prosthetics to only those deemed "qualified practitioners" and "qualified suppliers." The qualifications were defined in the statute and included state O&P licensure (if applicable) and accreditation by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC), the Board of Certification/Accreditation, International (BOC) or an accreditor deemed essentially equivalent by the HHS Secretary.

Unfortunately, CMS has never implemented the required claim edits at the DME MAC level to fully implement BIPA 427. CMS has asserted that they have implemented such edits, but a comprehensive analysis of the Medicare data by Dobson DaVanzo and Associates, LLC, has demonstrated otherwise. We would be happy to share this analysis upon request. In addition, the recent OIG reports cited above strongly suggests that CMS continues to pay claims submitted by inappropriate providers who are unqualified to submit correct orthotic and prosthetic claims.

CMS' issuance of CMS Transmittal Change Request (CR) 8390 on August 2, 2013, substantiates our claims further. This Transmittal modifies CR 3959 (issues in 2005) which required CMS contractors to implement claim edits for providers and suppliers of custom orthotics and prosthetics in 9 states with O&P licensure statutes. If actually implemented, this would have denied claims for custom orthotics and prosthetics submitted by unlicensed O&P providers and suppliers. The claims data demonstrate otherwise.

CMS has asserted for several years that it has implemented claim edits to ensure that only licensed providers are paid for custom O&P claims. But since the issuance of CR 3959, seven additional states have enacted O&P licensure laws. CR 8390, issued just a few months ago, calls for the implementation of claim edits for custom O&P care in five additional states. The fact that this CR was only recently issued demonstrates that CMS is not systematically restricting payment to qualified providers and suppliers of custom O&P care.

The OIG raised these same concerns in a 2012 report, "CMS Has Not Promulgated Regulations to Establish Payment Requirements for Prosthetics and Custom-Fabricated Orthotics," published in October 2012. It appears that O&P claims are allowed to pass through the Medicare billing system and be paid, regardless of the type of supplier submitting the claim. We believe this phenomenon has significantly contributed to the findings that many suppliers of prosthetic claims submitted invalid claims for lower limb prostheses.

We believe that most of the overpayments identified in the four OIG reports cited above could be easily remedied by simply enforcing existing law and having CMS create a claim edit based on the appropriateness of the qualifications of the supplier to the type of service billed. For this reason, we call on the OIG to hold CMS to full and immediate implementation of BIPA Section 427, federal law that addresses the OIG's concerns raised over the past 16 years related to the provision of orthotic and prosthetic care to Medicare beneficiaries.

Conclusion

The O&P Alliance is committed to improving quality, reducing unnecessary Medicare costs and, ultimately, restoring and protecting our patients' functionality and quality of life. We welcome the opportunity to work with the OIG and CMS to implement our suggested actions as well as devise additional ways to improve quality and reduce waste, fraud and abuse within the Medicare system.

We appreciate your time and the opportunity to offer our comments on these important reports. If you have any questions or would like to discuss our concerns and observations, please contact our Washington counsel, Peter Thomas, at 202-466-6550.

Sincerely,

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