



**American Orthotic &
Prosthetic Association**

AOPA URGES CONGRESS TO EXCLUDE ORTHOTIC SERVICES FROM THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

AOPA urges Congress to exclude orthotic services from the consolidated billing requirements of the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) payment methodology. This legislative adjustment would permit orthotists to be reimbursed separately from the PPS rate, and paid according to the established Medicare Part B orthotic and prosthetic fee schedule for orthotic services provided in the SNF setting. Such a change can be made budget neutral by appropriately adjusting the SNF Resource Utilization Group (RUG) payments to account for the exclusion of orthotic services.

Reason for Change

Over the past several years orthotic and prosthetic practitioners have catalogued a number of ongoing problems within the consolidated billing requirements of the SNF PPS that have resulted in patients being denied the prescribed orthotic care they need for treatment. When prescribed orthotic care is delayed or denied, patient care is negatively impacted – leading to higher long-term treatment costs and sometimes permanent medical damage.

Controlling costs to the detriment of patients

The original intent of the SNF PPS was to create a financial incentive to control costs. For instance, if a SNF was able to provide care for less than the Medicare payment rate, the facility would be able to retain any excess of Medicare payments over costs. If the cost of care exceed Medicare's payment rate, a SNF would be required to absorb those costs greater than payments.

However, SNFs have been controlling costs to the patient's detriment by:

- Denying the provision of prescribed orthotic devices;
- Asking the orthotic and prosthetic (O&P) practitioner to alter the delivery date of the orthotic device so that the practitioner can bill Medicare Part B directly;
- Substituting a lesser quality device than the one called for by the physician's prescription;
- Refusing to provide the O&P practitioner with a purchase order after learning how much the device will cost; or
- Declining to admit patients in need of orthotic services.

Documented Problems with the Delivery of Orthotic Services in SNFs

Below are a number of documented examples where O&P practitioners have witnessed the degradation of patient care under the current SNF PPS system:

- In **Connecticut**, a patient was admitted to a Medicare skilled nursing facility on 10/26/02 and required a custom fabricated ankle-foot orthosis. The SNF contacted an orthotic facility for a patient evaluation. The orthotist obtained the prescription from the physician but the SNF would not issue a purchase order for the device. The orthotic facility staff were told that under no circumstances can the device be delivered before 2/3/03, because that is when the patient would be eligible for Medicare Part B and the device could be billed directly to Medicare Part B.
- An orthotic facility in **Connecticut** was contacted on 6/7/02 to evaluate a patient in a Medicare Skilled Nursing Facility for a patient in need of a custom-hinged ankle-foot orthosis. The physician provided a prescription for this device on 6/14/02. The orthotist was told not to come back to the SNF for this patient until 8/12/02 because the patient would not need the orthosis prior to that date. The ankle-foot orthosis was delivered by the orthotist on 9/03/02. After the orthotist reviewed the patient's fact sheet from the SNF, it was clear that that the patient was eligible for Medicare Part A when the prescription was written on 6/14/02 but did not become eligible for Medicare Part B until 8/12/02.
- A Medicare patient in **Connecticut** was admitted to a SNF on 10/18/02. On 11/19/02, SNF staff called an orthotist to evaluate a patient for a custom articulating ankle-foot orthosis. The SNF would not issue a purchase order and suggested that the orthotist make it and deliver it to the patient after the patient was discharged. On 12/24/02 the physician's prescription was faxed to the orthotist from the SNF but a purchase order was still not given. On 1/15/03, the orthotist was called by the SNF to cast the patient and was told it could be delivered in a few weeks because that would be when "the patient would be ready to use it." The orthotist was called on 2/24/03 to deliver the device. The patient was no longer eligible for Medicare Part A and the orthotist could provide the device and bill Medicare Part B.
- An orthotic and prosthetic practitioner in **New Jersey** told AOPA that several Medicare skilled nursing facilities in the state has "scouts" that perform preadmission screening in the hospital setting. For example, if an in-patient requires a knee-ankle-foot orthosis, the SNF will attempt to have the patient sent home to have the prescribed device delivered before the patient is admitted to the SNF. That way, the practitioner can bill Medicare Part B. In other cases, the SNF will simply not admit the patient in need of expensive orthotic services because the SNF will be financial responsible for providing the orthosis.
- On 10/26/01, 1/24/02, 5/3/02, 6/19/02, 7/16/02, 8/5/02, 9/25/02, 10/4/02 and 11/23/02 an orthotic facility in **Connecticut** provided patients in Medicare skilled nursing facilities with orthoses. Each orthoses was authorized by the SNF with purchase orders. As of 2/28/03, invoices for each of these orthoses have not been paid. Each month a new invoice is sent to the SNFs. Phone calls have been made to the SNFs seeking payment. These calls have either not been returned or the orthotic facility staff is told by the SNF staff that the facility should not been issued the purchase order.

- An O&P facility in Montgomery, AL receives calls from SNFs to provide orthotic services to patients only when they are about to be discharged. On one occasion, when a practitioner was called in to evaluate a patient for an orthotic device, the Medicare patient was wearing a prefabricated brace. The SNF instructed the practitioner to provide a custom-fabricated brace to be delivered only when the patient returned home. This arrangement permits the orthotist to bill Medicare Part B directly.
- Many more examples are available.

SNF background information

- Congress established a prospective payment system (PPS) for Medicare skilled nursing facilities (SNFs) in the Balanced Budget Act of 1997. SNFs receive a per diem payment rate adjusted for geographic differences in labor costs and for differences in resource needs of patients. Adjustments for patients' resources are based on a classification system—resource utilization groups. This system assigns patients to one of 44 payment groups or RUGs, based on their clinical condition, functional status and use or expected use of certain types of services. With few exceptions, the payment is intended to cover orthotic services.
- The consolidated billing provisions of the SNF PPS stipulate that SNFs will no longer be able to unbundle services and permit an outside provider to submit a separate bill directly to the Medicare DMERC, while the patient is covered by Part A. Instead, the SNF must furnish the services either directly or under an arrangement with an outside provider such as an orthotist. The SNF, rather than the provider of the service, is required to bill Medicare. As a result, the outside provider of the service must look to the SNF, rather than to the beneficiary or the Medicare DMERC, for payment.
- The costs of orthotic services are included in the calculation of average costs of care for a typical patient in a RUG payment category paid by a Medicare fiscal intermediary.
- A number of services have been excluded from the SNF PPS since its inception. Such services include customized prosthetic services, emergency services, and magnetic resonance imaging, among others. These services were excluded because their costs were substantially more than the daily SNF payment rate and SNFs would have a financial disincentive to provide them or deny admitting patients likely to need such care.
- In 1999, the Centers for Medicare and Medicaid Services (CMS) calculated that the average covered stay for a Medicare beneficiary in a SNF was 23 days¹.
- There are about 15,000 SNFs nationwide providing care to Medicare patients. In 1999, most SNFs averaged about six Medicare patients each day and received about 13 percent of their

¹ Office of Information Services, Centers for Medicare and Medicaid Services: Data from the Medicare Support Access Facility, data developed by the Office of Research, Development, and Information—2002.

revenue from Medicare. By contrast, the care for about two-thirds of all SNF patients was paid for by Medicaid with the remainder generally paid for by the patients themselves.²

- Medicare paid SNFs approximately \$13 billion in 2000 to care for 1.4 million Medicare beneficiaries.³

² General Accounting Office Report (GAO-03-183), *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most But Not All Facilities*, p. 4.

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