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Exploring Possibilities

Thank you for the opportunity to voice our concerns to the committee. Unfortunately scheduling conflicts prevented our appearing, and we appreciate your willingness to accept our comments in this manner.

Our organization, American Prosthetics and Orthotics, Inc. provides rehabilitation care to individuals needing prostheses because of limb loss, or orthoses because of functional limitations from an accident, illness, or congenital complications. We have 8 locations in Iowa, and our organization has been a provider since inception of the Medicaid program.

Since management of the Medicaid program transitioned to the MCO's we have had difficulties with prior approvals, claims processing, receiving payments in a timely manner, and getting any response or acknowledgement of our concerns. These problems have resulted in additional costs to our organization, but more importantly has hampered our ability to provide services in a timely manner to the patient.

The MCCO's require prior approval for any one item or service on a claim that exceeds a certain dollar figure. Five hundred ($500.00), or seven hundred fifty ($750.00) dollars depending on the MCO are amounts that require prior approval. The mere fact prior approval is required is not the problem. The problem is that quite often the process may take significant time to complete and many times especially with pediatric patients, time is very critical.

Examples of how delays in the prior approval process affect care would include pediatric patients seen at the University of Iowa Hospitals and Clinics. Children with Cerebral Palsy may have heel cord lengthening or other corrective surgeries. They are placed in a cast immediately after surgery and within a few weeks are ready for the cast to be removed, and be measured for an orthosis to maintain the correction obtained in surgery. Because of the need to obtain prior approval, as well as the fact approval may not be granted in a timely manner, the process is unnecessarily delayed. This means the child must stay in a cast longer, and an additional trip to Iowa City is necessary.

Another example involves treatment of congenital club foot with a non-invasive series of manipulative casts. Casts are applied by University physicians at 2 week intervals starting as early as 3 weeks of age, and the feet are gently remodeled. After a series of 6-8 casts the feet are in correct alignment, and orthoses to maintain the correction are ordered. Again because of the prior approval process, additional time in the casts is necessary as well as another trip to Iowa City.

Before moving on I would reference one situation in which I felt an MCO's actions were extremely egregious, and in our opinion their denial and subsequent actions were based solely on cost. The service was for a prosthesis prescribed for a rather complex level of upper extremity amputation. During the process which entailed over 10 months United Healthcare demonstrated a consistent and organized

pattern of manufacturing excuses and delay tactics to avoid providing a medically necessary service to the patient. The patient eventually chose to no longer pursue appeal of the denial.

As noted earlier not only are there problems with prior approvals there are issues with claims processing which results in incorrect payments, and excessive delays in payment.

Prosthetic and orthotic services are billed under the "L" code system. The "L" code system is an add-on system which is different than most coding systems that tend to group procedures into global codes. The add-on system allows various components or modifications to be individually identified and billed appropriately. The individualized nature of the "L" code system is one of its best features but also the cause of confusion amongst payers

Appropriate coding of prosthetic and orthotic claims includes the use of certain modifiers. An example would be the modifiers "RT" and "LT". The respective letters indicate which extremity, right (RT) or left (LT) the prosthesis or orthosis is was provided for. If both modifiers, RTLT are used it indicates bilateral involvement meaning the patient required prostheses or orthoses for both extremities.

Use of the RT and LT modifiers is an issue the MCO's many times deal with incorrectly. AmeriHealth for a significant period of time could not understand that claims for foot orthoses and footwear billed with the RTLT modifiers represented involvement of both feet. They were paying for only one orthosis instead of two which had been prescribed and provided. Eventually we reached an understanding and they agreed to reprocess earlier claims and pay accordingly. Unfortunately that hasn't happened and we continue to try and collect those amounts due which date back to the implementation of managed care on April 1, 2016.

We continue to have problems with Amerigroup and UnitedHealthcare with certain modifiers and understanding units of service, especially when a claim involves provision of bilateral prostheses or orthoses. They process many of our claims as exceeding maximum number of allowable units and or frequency of service.

As an organization we are not opposed to the Medicaid program being administrated by managed care organizations. If the present system is to be viable the MCO's must improve their relationships with providers by being more attentive to their needs, but most importantly improve service to the patients covered by the Medicaid program.

Again thank you for the opportunity to present our concerns.

Respectfully submitted,

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