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STAKEHOLDER PERSPECTIVES

CONTEMPLATING HEALTH ECONOMICS, CODING AND REIMBURSEMENT IN ORTHOTICS, PROSTHETICS AND PEDORTHICS

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ABSTRACT

Reimbursement to U.S. healthcare service providers is largely transitioning from fee for service to fee for value for those clinicians who code using current procedural terminology and through their coding, describe their professional services. The Orthotic, Prosthetic and Pedorthic profession (O&P), currently codes using a system that describes the devices they evaluate for, fabricate, fit and maintain and their professional services are incorporated into their codes. These O&P codes, in contrast to those for other healthcare disciplines, are predominantly product based rather than service based, focusing on product features and function more than clinical service. This editorial manuscript provides a brief overview of the system the US O&P profession uses currently, particularly in the context of other healthcare professions transitioning to value based coding and reimbursement and culminates in a call to action for the profession to academically consider the strengths and weaknesses of the current system relative to alternative systems.

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KEYWORDS

Coding, Economics, Fee for Service, Orthotics, Prosthetics, Reimbursement

ECONOMIC SCIENCE IN ORTHOTICS, PROSTHETICS AND PEDORTHICS

Health economics in Orthotic, Prosthetic and Pedorthics (O&P) may be thought of as maximizing O&P related rehabilitation for those using these services given limited available resources. A body of literature exists on the subject of healthcare economics in O&P. Included in this body of work is a State of the Science Conference Proceeding from the American Academy of Orthotists and Prosthetists (AAOP- O&P's professional association in the U.S.) which includes twelve articles.¹ Contributions in this work include projects commissioned by the American Orthotic and Prosthetic Association (AOPA- O&P's trade association in the U.S.) such as a report comparing costs and outcomes in Medicare recipients receiving prosthetic care with those who did not receive prosthetic care and also

comparing those of selected orthotic care.² Additionally, building upon previously published clinical literature on microprocessor knee technologies for patients with transfemoral amputation which studied topics such as function, quality of life, safety and other clinical issues,³ AOPA commissioned a comprehensive economic analysis on the cost effectiveness of microprocessor knee systems compared to alternatives.⁴ This review concluded that MPK systems represent good, or potentially superior, value for money to comparable interventions in other healthcare sectors including total knee arthroplasty or implantable cardioverter defibrillators as cited examples.⁴

Among many positive benefits, the State of the Science Proceeding and health economic O&P literature referenced thus far succeeded in:

1. Raising awareness of health economic issues in O&P.
2. Pulling together O&P's body of knowledge in the health economic space.

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3. Identifying conclusions, evidence statements, recommendations, strengths, weaknesses and knowledge gaps in O&P health economic science.
4. Providing foundational, economic methodologies that may be used in O&P research.
5. Initiating a call to action for the O&P profession's research community to work toward adding economic analyses to ongoing and future research.

The aforementioned work also led O&P thought leaders to share and learn from healthcare disciplines outside of O&P to examine future directions relating to payment (i.e. reimbursement) structure. The purposes of this editorial are to point out a collection of health economic work in O&P, increase awareness of reimbursement changes taking place outside of O&P and to serve as a catalyst for conversation within the O&P profession by proposing a call to action related to potential next steps in advancing O&P's coding and reimbursement conversation.

REIMBURSEMENT CHANGES TAKING PLACE OUTSIDE OF O&P

In 1965, the U.S. Congress created Medicare under Title XVIII of the Social Security Act.⁵ In 1966, the American Medical Association (AMA), in concert with other specialty organizations, developed the iterative, Current Procedural Terminology (CPT) system. The CPT system was developed to provide standardized, uniform language for describing medical procedures and services and initially had no relationship with reimbursement.⁵ The AMA reviews and updates CPT codes annually. Healthcare innovation since development of the CPT code system has necessitated updates numerous times across the decades. The Health Insurance Portability and Accountability Act (HIPAA) of 1996, required the Department of Health and Human Services to name standards and code sets for electronic transactions of health information. This catalyzed further assessment of the CPT system, expanding beyond the reporting of procedures and services and into the reporting of pay for performance measures. The CPT coding system is the basis for service provider reimbursement when used with a relative value modifier.⁵

A detailed history of coding systems is beyond the scope of this manuscript but the abbreviated history presented serves to show that an interest in, and legislative action supporting early pay for performance concepts can clearly be observed as far back as HIPAA's passage in 1996.⁵ Legislative push away from fee for service (FFS) and toward fee for value (i.e. value over volume) has continued since then. For example, multiple medical specialists including urologists, gastroenterologists and orthopedists have begun chronicling the movement and emphasis of value over volume.⁶⁻⁹ More specifically, the Merit Based Incentive

Payment System (MIPS) is also being discussed by specialist communities.¹⁰

Cost, specifically rising healthcare cost, has been central to this discussion since the origins of reimbursed care provision.¹¹ While it is a core issue, cost represents merely half of the discussion as it relates to value.¹² This is because mathematically, value is equal to the difference in two interventions in terms of outcome divided by cost.⁶ While mathematically, the value discussion seems straight forward, it is actually very complex and includes many other factors such as patient selection, outcomes, risk stratification, patient registry, guideline based practice, care coordination and others. Use of clinical guidelines and registries and other best practices offer insight on practice decisions and may serve to reduce variability.⁶ As mentioned previously, the sum of all of this can be quantitatively described in terms of value, cost and quality or outcome. In medicine however, other variables are also measured and evaluated. These can include length of stay, readmission and complication rates.⁶

CONSIDERATIONS FOR POTENTIAL NEXT STEPS FOR O&P

The history of the development of the Healthcare Common Procedure Coding System (HCPCS) level II device L codes used by O&P to describe devices and services provided are documented elsewhere.¹³ Briefly, AOPA and Blue Cross and Blue Shield from South Carolina developed the template for the HCPCS L code system in the 1970's. It was piloted in 1979 and soon after, other insurance companies began following use of the system.¹³ The development of the associated fee schedule reimbursement methodology can be found in the U.S. Omnibus Reconciliation Act of 1987, which was implemented in 1989. The associated values were based on average payment amounts measured from 1986 to 1987 and are updated annually. Regulations for this methodology are in the U.S. Code of Federal Regulations (42 CFR 414.200). These coding and reimbursement methodologies have been associated with controversy by third party groups to government agencies who provide reimbursement based upon them and within the profession itself. It is important to note that in contrast to the CPT system, the L code system has not been maintained and updated with the same degree of modernization and applicability to current clinical O&P practice.

For instance, the Offices of the Inspector Generals for the U.S. Department of Health and Human Services and for the U.S. Department of Veterans Affairs have published numerous reports related to O&P. Some have been more clinically focused, exploring issues of population description, quality of care and other non-fiscal or less fiscally focused matters.^{14,15} However, the majority of these

have been related to questionable or fraudulent procurement, acquisition, payment and purchasing,¹⁶⁻²¹ coding²² or billing²³ related to O&P.

Additionally, editorial publications from members of the O&P community have also speculated as to whether or not the current and continued use of HCPCS L codes is a viable path forward.^{13,24,25} Among the issues cited in these publications are: delays and uncertainty in the coding application process and the seemingly diminishing success rate of receiving newly developed codes for newly developed technology. The latter issue is further being discussed as a potentially limiting factor in the investment and pursuit of research and development efforts to explore creation of new technologies. The DARPA/LUKE arm technology²⁶⁻²⁸ was cited in 2008 as an example of a government funded technological advancement that may not be assigned a code²⁵ and as of this writing in 2021, the component remains uncoded. Additional challenges with the current L code system include incorporation of professional service fees into the device reimbursement. This limits recognition of the contributions of the credentialed O&P clinician as a professional member of the healthcare team and perpetuates the image that the O&P clinician may serve more as device provider. Restated, because the L-codes describing O&P interventions are included within durable medical equipment (i.e. fee for device), the prosthetist-orthotist may not necessarily be afforded or regarded with comparable professional standing relative to providers who describe their services using CPT codes (i.e. fee for service providers). To the authors' knowledge, the O&P profession has not published data on the practitioner's work and service as assessed by time, mental effort, judgment, technical skill, physical effort, amortized educational costs (both entry level and continuing education), psychological stress and other factors as other professions have.

Other issues cited include an inordinately lengthy list of codes relative perhaps to other professions. Some O&P professionals have suggested there may be interest to reduce the number of codes while others have suggested that more codes, allowing greater descriptive specificity are needed. The debate over the number of codes is further complicated when considering assertions of misapplication of codes potentially due to misunderstanding. This is an issue echoed in a recent OIG report.²² There are numerous other points of debate with the current coding system for O&P. To be clear, not all of the O&P community agrees that the L-code system is dysfunctional or in need of replacement. Some have indicated it is adequate, some have indicated revision may be in order and still others may be interested in an alternative system all-together.^{13,24,25}

CALL TO ACTION

This manuscript provided a brief overview of the L-code system's origins, controversies, strengths and weaknesses. However, the purpose was to challenge the profession to begin to contemplate next steps of coding and reimbursement against a backdrop where all of healthcare and medicine and reimbursement is clearly moving from fee for service to fee for value while O&P is currently in a different place entirely using a fee for device model. It would seem change is imminent but maybe not. It would seem timely for O&P to academically evaluate the strengths, weaknesses, opportunities, threats, merits and other considerations of:

- staying with the current coding and reimbursement system,
- revising and updating the current system,
- alternate systems such as:
 - fee for service
 - fee for value
 - a hybrid system

Further, perhaps there would also be value in studying the history and methods used to formulate the coding and reimbursement systems of other providers and specialists as well as those of other nations.²⁹⁻³⁸ This could assist in determining if elements of other models could benefit O&P or if other methods and models would serve the profession better in their entirety. Moreover, such an exercise could potentially be what is needed to affirm the current system is the best system and should remain in place. If however the O&P profession were to embark on the aforementioned discussion and conclude that the current system is not meeting the profession's needs, perhaps completely reimagining the current HCPCS L coding and reimbursement methodology may be in order. To do this, it may be useful to objectively study and quantify the value of O&P professional service using methodologies outlined and previously used by other professions. Moving toward a novel, RVU based coding and reimbursement model used by and known to work for other healthcare service providers who also work with devices, could improve the professional standing of the O&P clinician within the interdisciplinary healthcare team and personify O&P professionals as service providers.

In summary, the prior SSC¹ was comprehensive and provided important professional awareness of and a call to action to engage more in economic science related to the O&P body of knowledge. The current call to action is in the context of legislative action driving all areas of healthcare toward value over volume. This is essentially driven by aligning incentives in such a way to prioritize the patient's interests, in terms of their outcomes above all other considerations. In this, it seems wise for professions to lead and be an active part of change or risk having legislators

and payers make decisions on behalf of involved professions.

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DECLARATION OF CONFLICTING INTERESTS

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