



# THE COPA CONNECTION

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## PRESIDENT'S MESSAGE RALPH NOBBE, CPO

Orthotic and Prosthetic Colleagues:

COPA has entered 2010 in a strong position despite the challenges created by the recent and continuing economic downturn. Our membership resolve has strengthened and growing membership continues to provide support and assistance.

The COPA Board of Directors has continued to build upon strong relationships with our "sister" organizations in O&P, while retaining our focus to benefit the California O&P business environment. To that end, we have partnered with WAMOPA to present a combined educational conference in May. COPA continues focusing on the business needs of our state while providing educational value to our membership.

Several dark clouds and significant challenges for California have already presented themselves for the coming year and are being scrutinized for further impacts to California. National health care reform policy will impact COPA strategy for legislation to further expand O&P coverage in the

*(Continued on page 2)*



Ralph Nobbe, CPO

## UNDER THE DOME

BRYCE W.A. DOCHERTY, EXECUTIVE DIRECTOR/LOBBYIST

### "The Trigger Proposal Will Eliminate O&P Coverage in Medi-Cal"



Governor Schwarzenegger's proposed budget for 2010-11 anticipates receipt of \$6.9 billion in additional resources from the federal government. Failure to secure these funds would "trigger" a number of additional cuts, including the elimination of the remaining Medi-Cal optional benefits **INCLUDING ORTHOTICS & PROSTHETICS!** Other affected services include: Hearing Aids; Physical Therapy; Occupational Therapy; Independent Rehabilitation Facilities; Outpatient Heroin Detox; Medical Supplies; and Durable Medical Equipment.

While past proposals to eliminate these services have failed, a number of optional benefits

were actually scratched in the current budget (most notably adult dental). Unlike other Medi-Cal cuts, the elimination of these benefits was not overturned by the courts. Given the likelihood that the requested federal funds will not be forthcoming, the lack of other cost cutting alternatives, the steadfast refusal to raise revenues and the potential "savings" associated with their elimination, it is entirely possible that **O&P WILL BE ELIMINATED EFFECTIVE JULY 1, 2010.**

COPA has embarked upon one of the most aggressive advocacy fights in our history to prevent these budget cuts.

*We continue our aggressive campaign to prevent the proposed elimination of O&P services*

*(Continued on page 2)*

**BOARD MEMBERS**[Ralph Nobbe, CPO](#)**President**[Lars Jensen, CP](#)**Vice President**[Rick Chavez, CPO](#)**Immediate Past President**[John Crane](#)**Secretary/Treasurer**[Tom Beall, CPO](#)**Board Member**[Gary G. Bedard, CO, FAAOP](#)**Board Member**[Kel Bergmann, CPO](#)**Board Member**[Harry Brandt, CO, BOCO](#)**Board Member**[Mark Conry, CPO](#)**Board Member**[Robert Jensen](#)**Board Member**[Karl Lindborg, CPO](#)**Board Member**[Bryce W.A. Docherty](#)**Executive Director/  
Lobbyist*****President's Message, cont'd.***

commercial marketplace. A long-term goal of strengthening accreditation standards for federal program providers and beneficiaries will also provide opportunity for improved safety for O&P patients in California.

The recurring state budget crisis continues to dictate the COPA business and legislative agenda. Gov. Schwarzenegger's recent budget proposal again places O&P coverage at risk under Medi-Cal. His current proposal includes elimination of all optional benefit categories including O&P. COPA is aggressively monitoring the progress of this budget proposal. Elimination of the optional benefit categories would eliminate all funding of O&P services to Medi-Cal beneficiaries. Retention of the Medi-Cal O&P benefit remains our greatest priority.

All of these activities and efforts will require significant COPA resources. Your assistance and contributions to the COPA PAC are required to allow COPA to engage in these activities to support your business. Your support is needed more than ever. Dig deep – you can't afford not to!

Thank you and I hope you enjoy this issue of *The COPA Connection*.

***Under the Dome, cont'd.***

in the Medi-Cal Program with a special "Thank You" to Jeff Collins with Cascade, COPA Board member Harry "JR" Brandt, COPA Board member Kel Bergmann with SCOPE, and COPA Board member Bob Jensen with Lawrence Orthopedic for their extraordinary outreach on this issue. Also, special-special "Thank You" to our national partners at ACA, AOPA and AAOP for unprecedented access to their resources. Lastly, special-special-special "Thank You" to Jeff Zeller with Spectrum Prosthetics who got his local TV station to cover this issue at his facility!

The following members have also "stepped up" big time by answering the call for COPA PAC contributions: Hanger Prosthetics & Orthotics (\$5,000), Nobbe Orthopedics (\$1,500) and Breakey Prosthetics (\$1,000).

This will continue to be an "All Hands on Deck" effort and we've only just begun!

Click [here](#) to read the fact sheet and [here](#) for the actual DRAFT legislative language provided by the California Department of Health Care Services (CDHCS) that outlines the proposed O&P elimination. Also, click [here](#) to read our "Arms and Legs are NOT a Luxury" fact sheet that will accompany our other collateral materials as we visit with legislators and budget committee staff, etc. Lastly, click [here](#) to read the wonderful national press release distributed jointly by AOPA and ACA. Please use the press release to also reach out to your local newspapers and TV stations. Please also use the fact sheet as talking points when discussing this issue with the media or other stakeholders.

In addition to COPA waging our own individual effort to prevent elimination of O&P in Medi-Cal – we're also part of a larger coalition representing ALL effected optional benefit providers, businesses, etc. This coalition has hired a very high profile media and public affairs firm to coordinate the overall outreach. To this end, please continue to coordinate any and all of your specific outreach through me, so I may coordinate with the larger outreach effort as needed.

Thus far, COPA has testified before the Senate Budget Subcommittee #3: Health and Human Services to OPPOSE the proposed "trigger" elimination of O&P benefits in the Medi-Cal Program. We are delighted to report that the subcommittee unequivocally AGREED

(Continued on page 3)

## Did You Know?

### **CMS CONSIGNMENT CLOSET RULE RESCINDED**

CMS officials alerted regulatory stakeholders that the “consignment closet” rules (scheduled to take effect in March) have been rescinded to allow for further review and consideration. The agency is considering rulemaking to address this issue in the future. This means that the current rules governing consignment closets under Medicare are still in place.

The consignment closet policy outlined by CMS in a transmittal issued in September of last year would have essentially prohibited arrangements where an enrolled supplier of durable medical equipment, prosthetics and supplies (DMEPOS) maintains inventory at a practice location which is not owned by the enrolled DMEPOS supplier, but by the physician, non-physician practitioner or other healthcare professional. The rescinded rule would have required physicians (physician or non-physician practitioner) to take possession of DMEPOS items who then would have had to bill for the equipment using their own supplier billing number. In addition to being impractical for physicians and Medicare beneficiaries, such an arrangement would have likely violated the physician ownership and referral statute—known as the Stark law.

This means that Stock and Bill continues as per current policy under Medicare.

### *Under the Dome, cont’d.*

with us and recommended REJECTION of these cuts!! However, our fight is FAR from over. The Gov. Schwarzenegger Administration testified that they are analyzing the effect of the recently passed federal health care reform package mandates on the California Medi-Cal Program. Therefore, we expect a revised budget proposal by Gov. Schwarzenegger in May (referred to as the May Revise) that will reconfigure their revenue estimates and potential cuts. We also need to keep up the fight to ensure the rejection recommendation by the full Senate Budget Committee and work to ensure the Assembly Budget Subcommittee takes similar action!

COPA, our California patient and industry family in conjunction with our national partners will certainly keep you informed as all this unfolds. In the meantime, please encourage others to join COPA and contribute generously to our COPA PAC. Those documents are further down as well.

COPA is also in the process of obtaining a video copy of the hearing for distribution but below is ONLY ONE of the specific examples (i.e. scoliosis) that we brought the attention of the Senate Budget Subcommittee:

“This is a custom molded orthotic that is used to correct severe curvature of the spine. If not treated at a young age and before the spine has reached growth maturity, scoliosis can cause diminished lung capacity and possible death due to severe compromised organ function. If no such orthotic bracing is provided by Medi-Cal then physicians would elect neuromuscular spinal infusion to correct the curvature. An invoice for such a procedure would cost \$294,000 with an expected Medi-Cal reimbursement of \$14,000. The expected Medi-Cal reimbursement for a highly customized orthotic to treat scoliosis is approximately \$2,000. An adolescent may need one or two braces during the course of treatment for a total Medi-Cal cost of \$2,000 - \$4,000. This represents an overall Medi-Cal savings of \$10,000 - \$12,000! BOTTOM LINE: Orthotic & Prosthetic Medi-Cal Coverage WILL SAVE MONEY!

P.S. Lars Jensen and Bryan Hayes from Hanger have stepped up BIG TIME to provide me with a “box of love” containing various custom orthotics and prosthetics customarily provided to Medi-Cal patients. Much thanks to Bryan personally delivered and walked me through the cost, use, benefit et al of these devices. Special “Thank You” also to Bob Jensen for the specific “sad but true” real life scoliosis example.

To learn more about the other legislation COPA is involved in this year, please see the legislative report further down in this edition of The COPA Connection.

*“If you miss a day “Under the Dome” – you miss a lot!”*

# ANNOUNCEMENTS & ALERTS

## SAVE THE DATE!

### WAMOPA-COPA Education Conference May 13-15, 2010

COPA is building off the success from the education conference on May 10, 2009, at Shriners Hospital in Los Angeles by jointly sponsoring the Western and Midwestern Orthotic and Prosthetic Association (WAMOA) education conference at John Ascuaga's Nugget in Reno, NV on May 13-15, 2010. The goal of COPA is to provide the membership an ongoing educational opportunity that is topical, centrally located and cost effective.

A special room rate of \$96.00 can be made by calling 1-800-648-1177. Make sure you mention that you are with the WAMOPA-COPA convention! Here are some of the highlights for the 3 day event:

The three day program will be featuring CEU accredited (24 credits approved!) Professional programs for ABC, BOC, and C.PED attendees presenting new products and new patient care procedures.

The two day accredited (16 credits approved) Technician Program on Friday and Saturday addresses current and new cutting edge fabrication techniques.

For more information or to register, please visit [www.wamopa.com](http://www.wamopa.com).

### COPA Annual Business Meeting Saturday, May 15, 2010

COPA will be hosting its Annual Business Meeting on Saturday, May 15, 2010 at 12:00 PM in conjunction with the jointly sponsoring the Western and Midwestern Orthotic and Prosthetic Association (WAMOPA) education conference at John Ascuaga's Nugget in Reno, NV. At this Annual Business Meeting COPA members will approve the annual fiscal budget, elect the newest board of directors and conduct other business. Please plan on attending.

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## ***Call for COPA Board of Directors Nominations***

COPA Nominating Committee is now accepting nominations for five seats on the 2010-2012 Board of Directors. Nominations will be accepted until Friday, April 30, 2010. The slate of candidates will be distributed to the COPA Membership via email by Monday, May 3, 2010. The election will take place at the COPA Annual Meeting on Saturday, May 15, 2010, in conjunction with the joint COPA-WAMOPA Educational Conference at John Ascuaga's Nugget in Reno, NV. These board seats will take effect on Thursday, July 1, 2010, and expire on Sunday, July 1, 2012.

Board member duties include promoting COPA membership and activities, participating in decision-making functions relative to overall COPA priorities, attending monthly board meeting conference calls and serving on COPA committees.

Nominations MUST BE accompanied with a one-paragraph biography and relevant contact information (i.e. address, phone, fax, email, etc). For further information, please [contact me](#). Thank you in advance!



## CLAIMS ALERT!

It has been brought to COPA's attention that several insurance carriers are processing O&P claims incorrectly. Specifically, any line item claims in excess of one unit is being rejected as excessive units of service for that particular date of service. This trend has been identified with several carriers by several providers.

These carriers utilize a specific claims editing software package which incorrectly reduces the quantities for a line item to one unit only for a given date of service. The software is marketed to insurers as "helping them to reduce the paid claims expenses for DME and orthotics and prosthetics."

COPA is addressing this specific issue, with the specific California licensed carriers we have already identified, the specific software vendor and the California Insurance Commissioner's Office directly. These claims are being systematically processed – incorrectly. It is up to each individual office to verify correct claims processing and payment in accordance with any provider agreements and actual services rendered.

We advise all COPA members to alert your claims staff to monitor and appeal any and all underpayments. We suggest that you track the specific remit codes provided on your EOB or ERN and log these underpaid claims for each carrier. Resubmit underpayments in batch form, as paper claims and identify the specific code and quantity reductions. Any claims resubmissions for these incorrectly processed claims should be sent via certified mail with return receipt. You must identify the specific pattern of payment reductions for your primary payers.

By aggressively tracking underpaid claims and developing the pattern of incorrect processing you have the ability and ammunition to get these claims corrected, paid, potential penalties applied and future problems resolved. Your specific, individual provider agreement may provide you additional recourse for these claims, consult your attorney. As you collect these problem claims and identify the carriers, COPA can address the issue with the implicated insurers on behalf of all COPA members. COPA cannot provide individual claims assistance.

The claim adjudication codes on the explanation of benefits or electronic remittance notice will provide the guidance needed by your claims staff. The specific codes used may vary by carrier – although it is supposed to be consistent under HIPAA. These codes remain subject to interpretation at the claims reviewer level and usage will vary based upon edits the carriers impose within their own software. That code is your key to resolving these claim issues.

Electronic remittance notices must follow HIPAA guidelines and MUST reference the specific remit/status/adjustment codes. Electronic remittances are identified as Form 837. You can only receive these electronically, and only if you bill electronically. Insurers are not required to provide 837's on paper and generally will not do so. They are more readily available to those offices submitting claims electronically and can be downloaded generally within 24 hours of claims submission. However, your software vendor for billing services and/or clearinghouse should be able to assist with this process.

Combinations of one or any of the following codes will identify the specific adjustment/reduction type. The list is not all inclusive. Paper explanation of benefits (EOB's) is not subject to the same transaction detail identification. If you are not receiving electronic remittances, you have a much greater potential for claims reductions, without your knowledge.

O&P claims represent a very small percentage of the health care dollar. But each individual claim can be quite large and can appear to be "unbundled" or excessive due to the billing quantities - and thus appears to be a source of saving to the insurer.

## CLAIM ADJUDICATION CODES

10	All originally submitted procedure codes have been combined.
11	Some originally submitted procedure codes have been combined.
12	One or more originally submitted procedure codes have been combined.
13	All originally submitted procedure codes have been modified.
14	Some all originally submitted procedure codes have been modified.
15	One or more originally submitted procedure code have been modified
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
519	Adjustment Amount
520	Adjustment Quantity
521	Adjustment Reason Code Not covered more than once in a 12 month period.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
E056	Missing or invalid item quantity
E057	Missing or invalid item identification
M53	Missing/incomplete/invalid days or units of service.
M90	Not covered more than once in a 12 month period.
W056	Missing or invalid item quantity
W057	Missing or invalid item identification

## Attention All CEDI Trading Partners, Suppliers, Billing Services, Clearinghouses, and Vendors: Editing the Ordering/Referring Provider in DMEPOS Claims Delayed

### **The Centers for Medicare & Medicaid Services (CMS) has delayed the implementation of Phase 2 of CMS CR 6421 for DMEPOS suppliers and CR 6417 for Part B providers until January 3, 2011**

The delay in implementing Phase 2 of these CRs will give physicians and non-physician practitioners who order or refer items or services for Medicare beneficiaries to other Medicare providers/suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to Phase 2 implementation

As part of Phase 1 for CR 6421, CEDI implemented warning errors/edits to be returned on the CEDI GenResponse Report (GENRPT) if the referring/ordering provider submitted on the claim was not enrolled in PECOS and/or not eligible to order or refer services.

- Should a DMEPOS supplier receive one of these warning errors/edits on a claim? CEDI recommends the following:
- Contact the Ordering/Referring Provider to verify their eligibility with PECOS.
- Contact the Ordering/Referring Provider to verify how their name is listed with their PECOS enrollment and ensure the name submitted on the claim matches the PECOS record.
- CMS has made available a file that contains the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in PECOS that contain an NPI). This file is downloadable from the Medicare provider/supplier enrollment Web site [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll), click on "OrderingReferringReport" on the left-hand side. (This .pdf file contains approximately 800,000 records. Due to the large size of this .pdf file CEDI suggests you right click and select "Save as" before attempting to open this file. )
- Verify the Type I (individual physician's) NPI and name of the Ordering/Referring Provider is submitted on the claim. If the Type II (physician's group) NPI and name is submitted, a match will not be found on the PECOS file.

For DMEPOS suppliers:

- CEDI validates the NPI, first four characters of the ordering/referring provider's last name and first one character of the ordering/referring provider's first name to perform the edits.
- Verify the ordering/referring provider name is submitted on the electronic claims in all uppercase letters.
- Verify the name of the ordering/referring provider matches how the provider is enrolled in PECOS.
  - Do include spaces in last names. For example, if the ordering/referring provider's last name is "A BCDE" do not submit the last name as "ABCDE"
  - Do include special characters in last names. For example, if the ordering/referring provider's last name is "A-BCDE" or "A'BCDE" do not submit the last name as "ABCDE"
  - Do not use nicknames ("BOB" for "ROBERT")
  - Do not use credentials ("DR JOHN" for "JOHN")
- Many ordering/referring providers are getting their enrollment information into PECOS or are updating their enrollment information. It may take some time for a Medicare enrollment contractor to process these enrollment applications. Once an application has been approved, the ordering/referring provider will have an enrollment record in PECOS that contains the NPI. The CMS PECOS list will be updated periodically to include ordering/referring providers that have updated their enrollment information.
- Upon implementation of Phase 2, only accept and fill orders from eligible Medicare providers.

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

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1231 I STREET SUITE 203 SACRAMENTO, CALIFORNIA 95814 (916) 446-4343

### AB 2470 (De La Torre) Individual Health Care Coverage

**Introduced:** 02/19/2010  
**Amended:**  
**Status:** Asm. Appropriation Committee Hearing: 4/14/10

**Sponsor:** CA Medical Association

**Analysis:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits the Director of the Department of Managed Health Care and the Insurance Commissioner from approving a health care service plan contract or health insurance policy without a finding that the application for the contract or policy conforms to specified requirements. Existing law prohibits the cancellation or nonrenewal of an enrollment or subscription by a health care service plan except in specified circumstances, including failure to pay the charge for the coverage, fraud or deception in the use of services or facilities, or other good cause as agreed upon in the contract. Existing law prohibits the nonrenewal of individual health benefit plans by a health insurer except in specified circumstances, including for nonpayment of premiums or for fraud or intentional misrepresentation of material fact.

This bill would require the director and the commissioner to jointly, by regulation, establish standard information and health history questions to be used by health care service plans and health insurers for their individual health care coverage application forms, as specified, and, on and after January 1, 2012, would require all individual health care service plan and health insurance applications to be reviewed and approved by the director or the commissioner, respectively, before use by a health care service plan or health insurer.

This bill is a reintroduction of AB 2 (De La Torre) from last year, which was vetoed by Gov. Schwarzenegger but COPA adopted a position of Support/Low.

**Priority:** Low

**COPA Position:** *Support*

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## AB 2586 (Chesbro) Health Care Coverage: Network Modification: Contracting Providers

**Introduced:** 02/19/2010  
**Amended:** 04/05/2010  
**Status:** Asm. Health Committee Hearing: 4/13/10

**Sponsor:** CA Medical Association

**Analysis:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a plan to obtain department approval prior to a material modification of its plan or operations and requires a plan to take specified actions prior to terminating a contract with a provider group or a general acute care hospital. Existing law imposes specified requirements with respect to the accessibility of services provided by both plans and insurers.

This bill would require a plan or an insurer that contracts with providers to obtain approval from its regulating department prior to implementing a network modification, as defined, and would require the plan or insurer, in order to obtain approval, to demonstrate that the modified network would meet certain access requirements. The bill would require plans and insurers to notify affected providers and enrollees or insureds of the modification.

**Priority:** Low

**COPA Position:** *Support*

## SB 810 (Leno) Single-Payer Health Care Coverage

**Introduced:** 02/27/2009  
**Amended:** 01/13/2010  
**Status:** Asm. Desk

**Sponsor:** Health Care for All

**Analysis:** This bill would establish the California Healthcare System to be administered by the newly created California Healthcare Agency under the control of a Healthcare Commissioner appointed by the Governor and subject to confirmation by the Senate. The bill would also make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services.

**Priority:** Low

**COPA Position:** *Watch*

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**SB 1163 (Leno)****Health Care Coverage: Denials: Premium rates**

**Introduced:** 02/18/2010  
**Amended:** 04/05/2010  
**Status:** Sen. Health Committee Hearing: 4/21/10

**Sponsor:** Author

**Analysis:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would require a health insurer that offers health care coverage in the individual market to provide an individual to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in writing. With respect to both health insurers and health care service plans issuing individual policies or contracts, the bill would require that the reasons for a denial or a higher than standard rate be stated in clear, easily understandable language. The bill would require notice of a change to the premium rate of coverage to be provided at least 180 days prior to the effective date of the change.

**Priority:** Low

**COPA Position:***Support*

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**SB 1169 (Lowenthal) Health Care Coverage: Claims: Prior Authorization: Mental Health**

**Introduced:** 02/18/2010  
**Amended:**  
**Status:** Sen. Health Committee Hearing: 4/14/10  
**Sponsor:** Author

**Analysis:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to have written policies and procedures establishing the process by which the plans or insurers prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers of health care services for enrollees or insureds. Existing law requires health care service plans and health insurers to reimburse uncontested claims within 30 or 45 working days and specifies that a claim is contested if the plan or insurer has not received a completed claim and all information necessary to determine payer liability.

This bill would require plans and insurers to assign a tracking number to a claim or provider request for authorization, upon receipt thereof, and to provide acknowledgment of receipt thereof, including identification of the tracking number, to both the provider and the enrollee or insured, as specified. With respect to claims that are contested on the basis that the plan or insurer has not received all information necessary to determine payer liability for the claim, the bill would require the plan or insurer to provide acknowledged-

**Priority:** Low

**COPA Position:** *Support*

**SB 1471 (Padilla) Insurers: Orthotic and Prosthetic Devices and Services**

**Introduced:** 02/19/2010  
**Amended:**  
**Status:** Sen. Rules Committee  
**Sponsor:** Author

**Analysis:** Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health insurers to provide coverage for orthotic and prosthetic devices and services under terms and conditions that may be agreed upon between the policyholder and insurer, and requires that the device be prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license or ordered by a licensed health care provider acting within the scope of his or her license. This bill would make a technical, nonsubstantive change to the above-described provisions.

**Priority:** Low

**COPA Position:** *Watch*

# MEMBERSHIP APPLICATION

## CORPORATE MEMBERSHIP CATEGORIES: \$1,200 Annual Dues (please check applicable category)

- Corporate – Patient Care:** Any firm or corporation that is principally engaged in the business of providing O&P direct services is eligible for this membership category.
- Corporate – Supplier:** Any firm of corporation that is principally engaged in supplying O&P businesses is eligible for this membership category.
- Corporate – Allied Health:** Any organization, firm or corporation that is engaged in the allied health field that serves O&P clients and businesses is eligible for this membership category.
- Corporate – Associate:** Any organization that represents consumers of orthotic and prosthetic care or other professionals who may also provide services to orthotic and prosthetic consumers is eligible for this membership category.

## INDIVIDUAL MEMBERSHIP CATEGORIES: \$120 Annual Dues (please check applicable category)

- Individual – Certified:** Any practitioner who is currently certified and in good standing with the American Board for Certification in Orthotics and Prosthetics (A.B.C.) and/or the Board for Orthotist/Prosthetist Certification (B.O.C.) is eligible for this membership category.
- Individual – Technician/Fitter:** Any technician currently registered with the A.B.C. or any fitter certified by the B.O.C. is eligible for this membership category.
- Individual – Associate:** Any person with a professional interest in orthotics and prosthetics is eligible for this membership category.

\_\_\_\_\_  
(Name, Company)

\_\_\_\_\_  
(Address, City, State, Zip)

\_\_\_\_\_  
(Phone, Fax, Email)

NOTE: Please check here \_\_\_ if you decline to have 25% of your annual dues dedicated to the COPA Political Action Committee. Contributions or dues payments to COPA or COPA PAC are not deductible as charitable contributions for Federal income tax purposes. COPA estimates that 10% of your membership dues will be allocated to lobbying expenditures for the fiscal year 2009/2010, and are not deductible as business expenses.

Please make checks payable to: **COPA**

***SHARE*** this membership application with your colleagues so they can become a member of the premier orthotics and prosthetics association in California.

***Click here to view:***  
[Membership Registration Online!](#)

# POLITICAL ACTION CONTRIBUTIONS

## COPA POLITICAL ACTION COMMITTEE *CORPORATE* CONTRIBUTION FORM

**President’s Club (\$2,500-\$6,500):** These prestigious members include manufacturers, patient care businesses and individuals who want to be constant and consistent actors in the issues surrounding the O&P industry. In addition to receiving all of the benefits provided to Leadership Board and Golden State Club members also receive a specially designed President’s Club lapel pin; complimentary admission to all COPA events and Complimentary admission for one guest to attend a President’s Club event. In addition, President’s Club members may be included in “invitation only” receptions and functions with legislators whenever possible.

**Leadership Board (\$1,000-\$2,499):** These members receive a specially designed Leadership Board lapel pin; invitations to legislative briefings and receptions featuring key legislators who are active in healthcare policy and special recognition throughout the year at events and in COPA publications.

**Golden State Club (\$500-\$999):** These members receive a specially designed Golden State Club lapel pin and special recognition throughout the year.

### STATE LAW REQUIRES THE FOLLOWING:

\_\_\_\_\_  
(Name, Company)

\_\_\_\_\_  
(Employer or Occupation)

\_\_\_\_\_  
(Address, City State, Zip, Phone)

## COPA POLITICAL ACTION COMMITTEE *INDIVIDUAL* CONTRIBUTION FORM

**Silver Dollar Club (\$365 One Dollar per Day):** These prestigious members receive a specially designed Silver Dollar Club lapel pin and special recognition throughout the year.

**Future Framers Club (\$25):** These student members receive a Certificate of Appreciation for their contribution and education and training about effective advocacy and professional communication with legislators.

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Employer or Occupation)

\_\_\_\_\_  
(Address, City State, Zip, Phone)

NOTE: COPA PAC contributions are NOT deductible as charitable contributions for federal income tax purposes. Contributions may not exceed \$6,500 in one calendar year.

Please make checks payable to: **COPA PAC (ID#791961)**

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California Orthotics and  
Prosthetics Association

1231 I Street, Suite 203  
Sacramento, CA 95814  
Phone: (916) 446-4343  
Fax: (916) 446-4333  
E-mail: [bryce@thedoehertygroup.com](mailto:bryce@thedoehertygroup.com)



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## COPA'S MISSION...

*Promoting the art and science of Orthotic and Prosthetic practice to create and communicate innovative solutions for a positive patient experience.*

## A PLACE FOR EVERYONE AT COPA...

Strength is measured by numbers. COPA has galvanized support from the O&P business community by encouraging businesses of all sizes to join as corporate members. Today the organization is moving forward in representing the needs of the individual practitioner in all areas of career development, including educational seminars and a renewed commitment to licensure for California. In order to facilitate individual contributions to support COPA, new membership categories have been added to allow students, technicians and practitioners at all levels of the career path to join COPA and share in the march toward professional recognition in California.

## STANDING ON SUCCESS...

COPA has a proven track record in legislation, association governance and membership responsiveness. Representing the field since 1970, COPA is an organization that has the resources to bring the community of O&P together as one voice to strengthen and solidify the unique characteristics that typify O&P professionals today. An Uncertain Future Without Your Support... For many years, the few have supported the many while all have prospered. The burden has now become too great and the pool of resources must be widened to ensure continued success.

The threats to the O&P community are real. This year alone, practitioners have been sanctioned by the Board of Pharmacy and the Physical Therapy Licensing Board. Individual lawsuits have been brought against practitioners who now stand in legal limbo with no statutory scope of practice.

Limited state resources to treat the poor and those injured on the job are being bargained away to those with stronger voices and wider support.

***What will history say about your commitment to O&P?***