AOPA In Advance SmartBrief
Breaking News
November 19, 2015

AOPA Headlines:

RAC Contractors Have Been Authorized to Re-Start Audit Activity

It has been remarkably quiet on the Recovery Audit Contractor (RAC) front for the last 18 months or so. As a result of the original RAC contracts coming to an end and new RAC contract proposals being submitted and reviewed, the number of additional documentation requests (ADRs) has been reduced significantly. CMS advised its original RAC contractors to essentially hold off on issuing new ADRs until new contracts were finalized and implemented. One of these new contracts would establish a single, national RAC contractor who would be responsible for RAC audits on all Medicare DMEPOS, Home Health, and Hospice claims. This contract was initially awarded to Connolly Healthcare who currently serves as the Jurisdiction C RAC contractor for all Medicare claims. While the contract award was issued in December 2014, a subsequent protest of the award initially delayed its implementation and eventually led to a CMS decision to issue new bids for all of the RAC contracts, including the national contract for DMEPOS, Home Health, and Hospice claims.

On November 16, 2015, CMS announced that while new bids for RAC contracts are being accepted and reviewed, the existing four RACs may continue to perform RAC reviews and may begin to issue additional ADR requests. This signals an effective end to the moratorium that was placed on new RAC activity in February of 2014. While it may take a few weeks for the current RACs to put in place the resources to re-start full scale activities, there is no reason to expect that they will not do so as soon as possible.

While this announcement is not an encouraging development, RAC audits are not new to the O&P community and hopefully we have learned some lessons from previous experiences with RAC auditors. When RAC audits began several years ago, O&P providers faced a new reality as far as what documentation was expected in order for claims to be paid and stay paid. Hopefully this

education has not been forgotten as a result of the slowdown in RAC audits and the impact of the RACs becoming more active will be significantly lower.

RAC audits for O&P providers are still limited to a maximum of 10 audits per Tax ID every 45 days. AOPA encourages everyone to make sure you are aware of these limits and to challenge any requests that exceed the limits. While nobody is happy to hear that the RACs are back in business, at least temporarily, the lessons of the past should make for a less stressful future. The CMS announcement regarding RAC audits may be found on the CMS website.

Questions regarding this issue may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

CMS Implements Final Rule on Comprehensive Care for Joint Replacement, Which Provides Incentive Payments to Hospitals to Reduce Volume of Services/Total Costs

On November 16, 2015, the Centers for Medicare and Medicaid Services (CMS) issued a final rule entitled, "*Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services*." This final rule represents CMS action under its Innovation Center to initiative its first foray into implementing post-acute care bundling (the objection by AOPA and others that Congress has never authorized CMS to invoke post-acute care bundling was skirted by CMS—click here to read AOPA's comments). The rule establishes a mandatory Medicare payment policy demonstration that will apply for hospital inpatient, outpatient, post-acute, and physician services rendered in connection certain Total Hip Arthroplasty (THA), Total Knee Arthroplasty (TKA), and select other lower extremity surgeries for the duration of the inpatient stay and 90 days following hospital discharge.

This policy would apply to hospitals in 67 Metropolitan Statistical Areas (MSAs), beginning on April 1, 2016 and lasting through December 31, 2020. The Proposed Rule had called for application in 75 MSAs and a start date of January 1, 2016, representing two of the most significant changes CMS made in the Final Rule.

Hospitals, physicians, and post-acute care providers would continue to bill and be reimbursed through Medicare Fee-for-Service (FFS), under their respective payment systems, for the duration of the CJR demonstration.

However, total Medicare Part A and Part B spending for services provided during the 90-day window would be reconciled against hospital-specific target expenditure amounts that are derived from a blend of hospital-specific and regional historical Medicare Part A and B payments for CJR episodes, transitioning from primarily provider-specific to completely regional pricing over the course of the 5 performance years.

For Year 2 through 5, after reconciling actual spending with the target prices, hospitals (and any providers with which the hospital has entered into a joint risk-sharing contractual arrangement for the CJR Model) would be required to repay the excess costs above the target price up to certain "Stop-Loss Limits" that would vary by year, *e.g.* 5% Stop-Loss Limit in Year 2. There would be no repayment obligation for excess costs in Year 1 of the program. Similarly, hospitals and their risk-sharing contractual partners that achieve actual episode spending below the target price (and meet quality performance thresholds on required quality measures) would be eligible to earn a reconciliation payment for the difference between the target price and actual episode spending, up to the Stop-Gain Limit.

CMS Finalizes Stark Law Changes in CY 2016 Medicare Physician Fee Schedule Final Rule

This past July, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that, in many ways, signaled the agency's intent to ease the burden of complying with the law. On October 30, 2015, CMS unveiled its final changes in this iteration of Stark Law rulemaking as part of the CY 2016 Medicare Physician Fee Schedule final rule (the "Final Rule"). The Final Rule makes several significant changes, including new exceptions for the recruitment of non-physician practitioners and timeshare arrangements.

The regulatory changes will become effective January 1, 2016, with the exception of the changes related to determining the level of physician ownership in physician-owned hospitals, which will take effect January 1, 2017.

While AOPA does not foresee a significant impact of the new Stark law changes to O&P, here are the area of new exceptions: Non-physician Practitioner Compensation Assistance; Timeshare Arrangements.

The Final Rule includes clarifications for Physician-owned Hospitals; (a. Clarification of Ownership Disclosure Requirements; b. Modification of Definition of Physician Ownership or Investment.) The Final Rule revised procedural requirements including recruitment and retention changes, and an update to the language for retention payment in underserved areas.
Read the complete updates here.

Read the November Issue of the *O&P Almanac* Online

Improving With Age | Page 20
AOPA's annual Wine Tasting and Auction has become a true 'experience.' **Read More**

Cover Story: Foot Care for the Ages | Page 22
Great awareness of early intervention for pediatric flatfoot and other issues will prevent complications for patients later in life. **Read More**

Leadership Series: Broadening Our Scope | Page 30
Providing ancillary services may offer benefits for both O&P facilities and patients. **Read More**

Page 18 – Reimbursement Page – Earn 2 CE's
Read the Column and Take Your Quiz Here.

Mark Your Calendars for the 2016 Webinars

WEBINAR WEDNESDAYS

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2016 Webinar Topics

January 13: Prepayment Reviews: What You Need to Know to Pass

February 10: SNF Billing: Beyond the Basics (The Ins and Outs)

March 9: Shift the Liability: The Proper Use of the ABN Form

April 13: Understanding Shoes, Mastectomy, & Other Policies

May 11: When Things Go Wrong: Making Lemonade out of Lemons

June 8: Physician Documentation: How to Get It & How to Use It

July 13: Strategies and Levels: How to Play the Appeal's Game

August 10: The Supplier Standards: Are You Compliant?

September 14: Fill in the Blanks: Know Your Forms

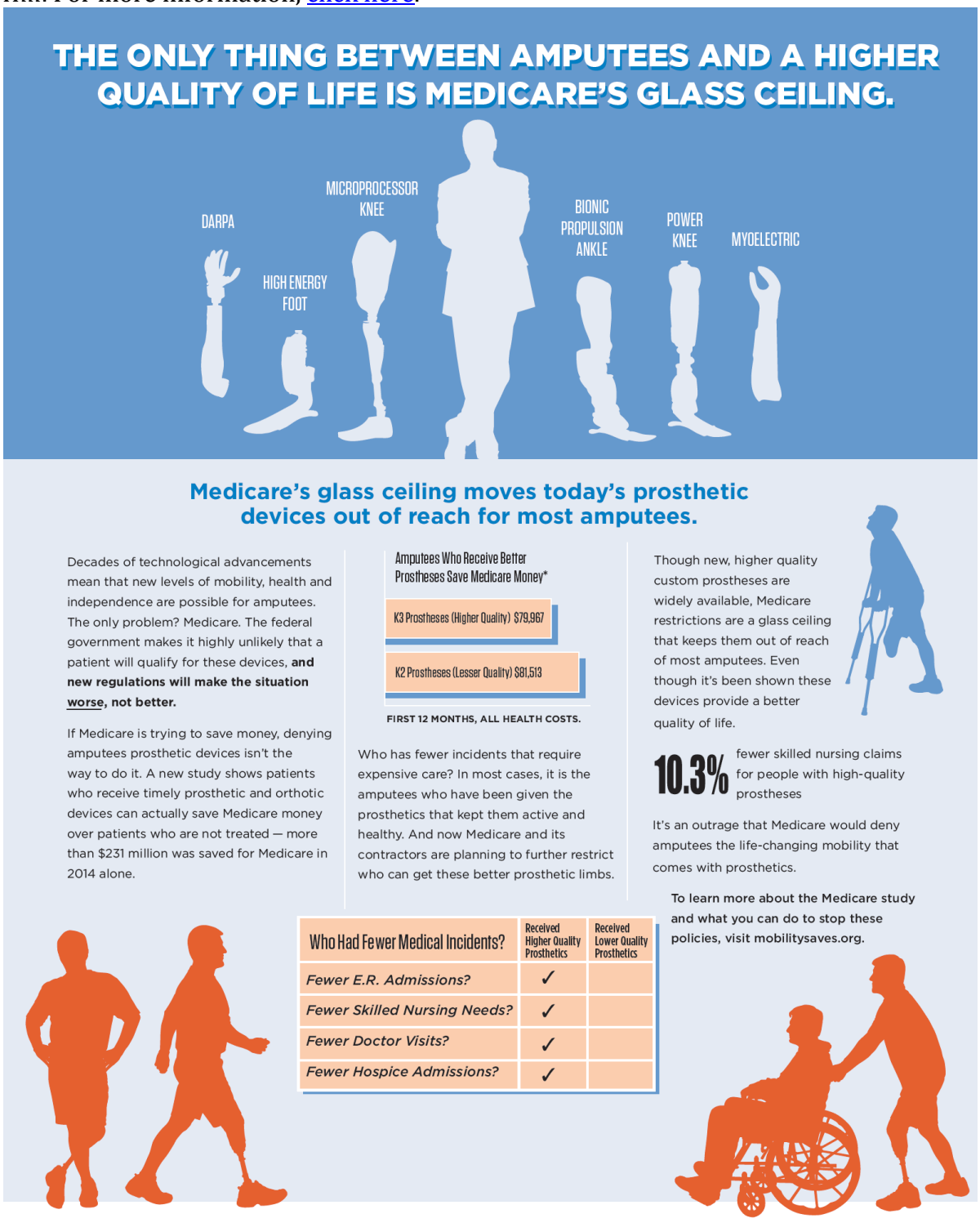
October 12: KO Policy: The ABC's of the LCD and PA

November 9: Don't Miss Out: Are You Billing For Everything You Can?

December 14: New Codes and What Lies Ahead for 2017

Share AOPA's Ad on the "Prosthetic Glass Ceiling"

Consider sharing AOPA's print ad on your website that appeared in the *Washington Post* and *The Hill*. For more information, click here.



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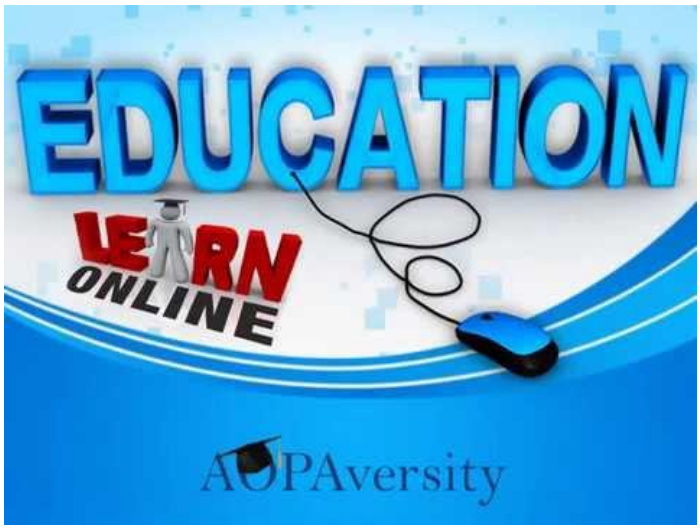

Upcoming AOPA Events

December 9, 2015	*Bringing in the New Year: New Codes and Changes for 2016* AOPA Webinar Learn more or register here
January 2016	Mastering Medicare: Essential Coding & Billing Techniques Seminar Tampa, FL
January 13, 2016	*Pre-Payment Reviews: What You Need to Know to Pass* AOPA Webinar Learn more or register here