AOPA In Advance SmartBrief
Breaking News
May 24, 2016

AOPA Headlines:

DME MACs Revise Knee Orthosis Policy

The DME MACs have recently published a revision to the Knee Othosis Local Coverage Determination (LCD) and Policy Article (PA) that will be effective for dates of service on or after June 2, 2016.

The primary revisions to the LCD and Policy article include the addition of ICD-10 diagnosis codes that allow providers to indicate whether the encounter was considered an initial, subsequent, or sequela encounter; and incorporation of language from the DMEPOS quality standards regarding the definition of custom fabricated orthoses. The revision also incorporates standard documentation language found in other O&P policies.

The revised knee orthosis LCD and Policy Article may be reviewed by clicking here.

Questions regarding the policy revision may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

CMS Issues Press Release on DMEPOS Payment Amounts

CMS has issued a press release, "Monitoring Data Shows Adequacy of New Payment Amounts for DMEPOS in Non-Competitively Bid Areas". The content of the CMS Press Release is below. The press release is also available on the CMS website.

Date 2016-05-17
Title Monitoring Data Shows Adequacy of New Payment Amounts for DMEPOS in Non-Competitively Bid Areas
Contact press@cms.hhs.gov

Monitoring Data Shows Adequacy of New Payment Amounts for DMEPOS in Non-Competitively Bid Areas.
Results Suggest No Negative Impact on Beneficiary Access in Urban and Rural Areas.

Starting in 2011, section 1834(a)(1)(F) of the Social Security Act (the Act) required CMS to use competitive bidding to set payment amounts for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for certain areas in the country. As implementation of the DMEPOS competitive bidding program has rolled out in areas across the country, CMS has been using real-time data monitoring to ensure that Medicare beneficiaries continue to receive the medical equipment they need. This data monitoring tracks access to items and services and a number of clinical outcome measures such as mortality, hospitalizations, and emergency room visits. By all measures, the DMEPOS competitive bidding program has been a great success for beneficiaries and the taxpayers.

Section 1834(a)(1)(F) of the Act also required that the DMEPOS fee schedule amounts paid in non-competitive bidding areas be adjusted based on information from the competitive bidding program beginning on January 1, 2016. CMS started to phase-in these new rates with a blend of 50 percent of the unadjusted fee schedule amounts and 50 percent of the adjusted fee schedule amounts on January 1, 2016. CMS is using the same monitoring system we use in competitive bidding areas to ensure beneficiaries are receiving the equipment they need.

The monitoring data posted today shows that suppliers in all areas where the adjusted DMEPOS fee schedule rates have been implemented have continued to accept these adjusted rates as payment in full, suggesting that the adjusted fee schedule rates continue to be more than adequate in covering the costs of furnishing the DMEPOS items in all areas.

A valuable indicator of whether payment amounts are sufficient is the percentage of claims that suppliers submit as accepting assignment, meaning that the suppliers accept the Medicare fee schedule amount as payment in full. Suppliers in non-competitive bidding areas are not required to accept assignment of Medicare claims for DMEPOS items in accordance with the Medicare statute. This means that if an adjusted fee schedule amount is not sufficient to cover the costs of furnishing the item to a particular beneficiary in the supplier's service area because of where the beneficiary lives or for other reasons, the supplier can decide not to accept assignment of the claim and can collect the extra money to cover their costs directly from the beneficiary. This payment from the beneficiary would be in addition to the coinsurance and deductible required by all beneficiaries for DMEPOS items.

The monitoring data posted today compares the rate of assignment of claims for DMEPOS items for the first four months of 2015 that were paid at the unadjusted fee schedule rates versus the rate of assignment of claims for the same items that were paid at the new partially adjusted rates for the first four months of 2016.

The data are broken out for eight geographic regions of the contiguous United States, as well as non-contiguous areas (i.e., Alaska, Hawaii, Puerto Rico, Virgin Islands, etc., combined). The data are also broken out to compare the rate of assignment of claims for DMEPOS items furnished in rural areas versus non-rural areas. The rate of assignment of claims in 2016 continues to be very high overall in both rural and non-rural areas. Finally, the data is broken out for several different categories of DMEPOS items.

Overall, there was no change in the rate of assignment for the first four months in 2016 (99.88 percent) compared to the first four months in 2015 (99.87 percent). There was also no change in the rate of assignment in rural areas in 2016 (99.90 percent) compared to 2015 (99.90 percent), while the rate of assignment in non-contiguous areas changed only slightly in 2016 (99.81 percent) compared to 2015 (99.90 percent).

The monitoring data are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/Fee-Adjustment-Monitoring.html

CMS expects to post additional data on assignment rates, access to items and services, and health outcomes in the near future.

Based on our monitoring efforts and the continued high voluntary acceptance of assignment across all non-competitive bidding areas, including rural areas and non-contiguous areas, CMS believes that the fee schedule adjustments implemented in January have not had a negative impact on beneficiary access to quality items and services. CMS will continue to monitor all data very closely leading up to and following the phase in of the fully adjusted DMEPOS fee schedule adjustments on July 1, 2016.

CMS Releases Proposed Rule for 2017 SNF Prospective Payment System

On April 25, 2016, the Centers for Medicare and Medicaid Services (CMS), published the annual proposed rule that will govern Medicare coverage of Skilled Nursing Facility (SNF) services through its established Prospective Payment System (PPS). Included in the proposed rule is an opportunity for the public to suggest additions to the list of HCPCS codes that are exempt from the SNF PPS system and therefore, payable by the DME MACs as Medicare Part B services.

While most prosthetic services are currently exempt from SNF PPS, there are several codes that have been historically not included in the PPS exempt list and therefore must still be billed to the SNF directly. These include HCPCS codes that describe partial hands and feet as well as L5987 which describes a "shank foot system with vertical loading pylon." As it has done in the past, AOPA will provide formal comments requesting the inclusion of these codes in the SNF PPS exempt list. AOPA believes that these codes meet the regulatory requirement for SNF PPS exclusion (low volume and high cost) and should be added to the list of HCPCS codes that are exempt from SNF PPS.

The proposed rule may be viewed by clicking here.

Comments on the SNF PPS proposed rule will be accepted until 5 PM EDT on June 20, 2016. Instructions on how to submit comments are included in the proposed rule.
Questions regarding this issue may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

Registration is Now OPEN for the 2016 AOPA National Assembly

Registration is now OPEN

99th AOPA National Assembly
September 8-11, 2016
Hynes Convention Center, Boston, MA

Why should you attend?

- PLOT A COURSE FOR FUTURE SUCCESS with 5 concurrent sessions for Orthotists, Prosthetists, Pedorthists, Technicians, Business Owners and Managers
- Cruise through the stormy seas of REGULATORY RULES with answers you can only get from AOPA
- Navigate the country's LARGEST O&P EXHIBIT HALL
- Sail through spectacular general sessions with inspiring KEYNOTE PRESENTERS
- Earn more than 32 CE CREDITS
- Partake in FUN NETWORKING EVENTS
- Enjoy exciting and HISTORIC BOSTON BACK BAY
- Catch up with the ALUMNI CONNECTION
- Maneuver your way with CASE STUDIES AND SYMPOSIA
- GET ONBOARD with MDs, PhDs, Wound Care Specialists
- , Research Scientists, Attorney's, Business Experts and Top-Notch Practitioners

Learn more about the 2016 AOPA National Assembly

Register Now

Lawall at Hershey, Inc. Welcome a New Team Member

Lawall at Hershey, Inc. located in Hershey Medical Center has hired Erin MS Aulicino CO/L to join the Lawall team! Erin received her Masters of Science in Prosthetics and Orthotics from the University of Pittsburgh.

Revised Limitations on the Scope of Review for Redeterminations & Reconsiderations

The Center for Medicare and Medicaid Services (CMS) has recently issued a revised directive to its contractors handling appeals that are a result of a "complex prepayment reviews, complex post-payment reviews or automated post payment reviews". CMS has informed the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Qualified Independent Contractor (QIC) that during the redetermination and reconsideration levels they may only "limit their review to the reason(s) the claim or line item at issue was initially denied".

This means that the contractors may no longer deny your claim for a different reason upon further review of the claim, they may only review and make a decision based on the initial issue at hand. However, this limit doesn't apply to appeals that are the result of an automated pre-payment review denial. The limit on the scope of review only applies to appeals which are the result of denials due to complex prepayment reviews, complex post-payment reviews or automated post payment reviews.

This is a beneficial shift in policy. Previously, the DME MACs and the QIC could still "develop new issues and evidence at their discretion" and issue unfavorable decisions for any reason besides the one provided with initial determination; even on post-payment reviews. Now, they may only "develop new issues and evidence at their discretion" when a claim is denied on an automated pre-payment review basis only.

This revised directive and instructions only applies to redetermination and reconsideration requests received by the DME MAC or QIC on or after April 18, 2016. The revised instructions will not be applied retroactively. You may view the MLN Matters article which outlines these new directives here.

Attend the 9th Annual Wine Tasting & Auction

NINTH ANNUAL AOPA 2016
WINE TASTING
& Auction

During the 2016 National Assembly AOPA will be hosting the 9th Annual Wine Tasting & Auction, on Friday, September 9th from 6:00-8:00 PM. This exciting event provides attendees with a unique opportunity to mingle, network, learn about and taste a variety of wines, but most importantly raise awareness of and funds for AOPA's Government Relations outreach. Let's keep the tradition of success alive and make the 9th Annual Wine Tasting & Auction the best ever.

Please join the fun, the "good cause" and add to the continued success of the Wine Tasting & Auction by donating today! ***Your special donations are what make this event unique.*** Your donation may be one of the gems of your cellar, jewelry, artwork, wine glasses, a bottle of your favorite spirit, cigars, etc. We also have a team of personal shoppers who can locate that perfect item for you if you would prefer to make a monetary donation.

Please consider donating today! The donation form is available here.

Thank you in advance and we look forward to seeing at the 2016 National Assembly and the 9 Annual Wine Tasting & Auction.

Questions? Contact Devon Bernard *via email or at (571) 431-0854*

2016 O&P Benchmarking Survey is Now Available

Have you ever considered using a benchmarking survey to measure your company's financial performance to strengthen your business? If so, now is the time.

You won't want to miss this opportunity particularly if you have been asking yourself questions like these:

- *How does our spending on materials, advertising or other expenses compare with other companies similar to ours?*
- *Is our gross margin better or worse than other facilities of the same size?*
- *Are our employees generating enough sales?*

Opportunities to participate in the survey come around once a year. 2016 surveys were mailed to AOPA members May 1. **Participation for AOPA members is FREE**, and includes a complimentary final report (a $185 value) AND a free customized company report, comparing your company results to businesses of similar size and location. Participants this year will also receive a **FREE 2016 Coding Pro**, single user edition, with Medicare fee schedules for all 50 states and other customizable fee schedules.
BEGINS: Surveys mailed May 1, 2016 and open until June 21st
***YOUR INVESTMENT*:** 60 minutes to compile information for survey
COST: FREE published report and FREE customized company report for AOPA members
***HOW*:** Submit the survey online at: www.aopa-survey.com OR Complete the mailed hard copy, OR submit your financials and Industry Insights will confidentially enter the data for you.
IT's CONFIDENTIAL: Only Industry Insights, under a strict confidentiality agreement, knows your data.

Look for your survey in the mail or click here. Don't let this opportunity pass you by.
It's hard to chart a course for success if you don't know where you are starting from.

For questions or more information contact Bleppin@AOPAnet.org, 571-431-0810.

Join the Coding & Billing Experts in San Antonio

The AOPA Coding & Billing Experts are Coming to San Antonio!

AOPA's next Coding & Billing Seminar will be in San Antonio! Don't miss this opportunity to get the most up-to-date information to advance your O&P practitioners' and billing staff's coding knowledge.

Join your Colleagues June 13-14 in San Antonio!

At this seminar you will:

Visit the Alamo-just minutes away

- **Receive up-to-date information on Prior Authorization and other Hot Topics**
- **Ensure your Proof of Delivery meets Medicare Requirements**
- **Learn how to assess risk areas in your practice**
- **Learn successful appeal strategies and hints to avoid claim denials**
- **Practice coding complex devices, including repairs and adjustment**
- **Attend break-out sessions for practitioners and office staff**
- **Earn 14 CEs**

Where else can you get two jam-packed days of reliable, valuable O&P coding and billing information? Learn more.

Register Now

Upcoming AOPA Events

June 8, 2016	*Physician Documentation: How to Get It & How to Use It* AOPA Webinar Learn more or register here
June 13 & 14, 2016	*Coding & Billing Seminar* San Antonio, TX Learn more and register here
July 13, 2016	*Strategies and Levels: How to Play the Appeals Game* AOPA Webinar Learn more and register here