AOPA In Advance SmartBrief
Breaking News
September 29, 2016

AOPA Headlines:

AHRQ Announces Systematic Review of Clinical Literature on Lower Limb Prostheses

The Agency for Healthcare Research and Quality (AHRQ), the "government agency tasked with producing evidence to improve the quality of healthcare while working with partners to ensure that the evidence is understood and used," recently announced that it will be initiating a systematic review for lower limb prostheses. The systematic review will be performed through the Evidence Based Practice Center Program of the AHRQ—they will likely select a firm to conduct the review under contract-- and the stated purpose of the systematic review is "to examine the available clinical evidence that defines practices in the care of beneficiaries who require lower limb prostheses (LLP)."

While the announcement does not tie the systematic review to the work of the inter-agency taskforce assigned to review the delayed draft Local Coverage Determination (LCD) that was released by the DME MACs in the summer of 2015, it is very likely that the initiation of the systematic review for lower limb prostheses is related to the work of this taskforce.

AOPA will be working toward a timely and substantive meeting with representatives of the AHRQ in order to discuss existing systematic reviews for lower limb prostheses that have recently been completed through AOPA funding as well as the ongoing work and comprehensive systematic literature reviews and simulation modeling being conducted by the RAND Corporation including its assessment of the cost effectiveness of prosthetic intervention, as well as both previous and

new cost effectiveness studies based on Medicare data that have been developed by Dobson DaVanzo.

AOPA will continue to inform its membership of any developments in the status of the AHRQ initiated systematic review.

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

CMS Announces New Address for CERT Documentation Submission

The Centers for Medicare and Medicaid Services (CMS) recently announced that, effective October 7, 2016, documentation submitted in response to a CERT audit request should be sent to the following address:

CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228
Fax: 804-261-8100
Customer Service: 443-663-2699
Toll Free: 888-779-7477
Email: certmail@admedcorp.com

The address change is a result of the recent transition in CERT contractor duties that combined the medical review and documentation collection activities of the existing CERT contractor, Advamed.

This change applies **only** to documentation requests involving CERT audits. Documentation submitted in response to pre-payment reviews conducted by DME MAC contractors should continue to be submitted to the DME MAC address provided in the request.

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

HHS Request to U.S. District Court Rejected

O&P and Others Subject to RAC Audits Greatly Interested by U.S. District Court Decision to Reject an HHS Request for Delay of Court Action in Hospital Suit Challenging ALJ Delays in Excess of Statutory 90 Days

A Quick Synopsis

In 2014, the American Hospital Association filed suit in the federal District Court seeking relief because HHS and the Office of Medicare Hearings and Appeals (OMHA) have for many years egregiously exceeded the statutory provision which assures a provider who must return money to Medicare as a result of an audit a final ALJ decision within 90 days after filing a request for ALJ appeal. Originally, the District Court dismissed the case, but early this year the D.C. Circuit Court of Appeals reversed that decision and ordered that the case should go forward in the District Court.

HHS/OMHA asked for a delay of over a year (until September 30, 2017) citing proposed regs (to which both AOPA and the O&P Alliance responded) intended to reduce the backlog--which are somewhat problematic in their own right. The Court ruled not to approve HHS' request for such a delay, but rather that case will go forward with a hearing in two weeks.

Court Sees Likelihood that the Backlog and Delay in ALJ Decisions Will Grow, Despite Various Efforts by HHS/OMHA Proposed Rule

In his ruling rejecting the HHS request for delay, District Court Judge Boasberg said that even with the administrative changes proposed by HHS/OMHA, it would not reverse the backlog, but rather that the ALJ backlog/delay would nonetheless probably get worse, not better over several years. The increased claim settlement efforts, and appointing attorneys to undertake adjudication of appeals in the proposed regs, would, the Court said, at best reduce the growth of the backlog. The specifics of the delay are daunting. Without any remedial actions by either HHS/OMHA or Congress the projected number of appeal cases awaiting ALJ hearing would reach nearly 1.1 million. HHS reports average delay in 2016 is 850 days, but OMHA says in the third quarter of this year it took 935 day for appeals to get through the first three levels of appeal, not getting to a final ALJ decision. Reports from O&P patient care appellants seems to run closer to 4 years waiting time to get to an ALJ decision! HHS proposed changes to the RAC program, but these would impact just 7 percent of RAC cases. Finally, the judge underscored that several Congressional initiatives, e.g., the AFIRM bill had not moved much closer to enactment in the 7+ months since the Circuit Court of Appeals decision, nor did it appear likely that significant budget increases to hire substantially more ALJs would be enacted anytime soon.

The Appeals of RAC Decisions, and the Related Interest Due if Provider Wins May Be Making the Program Much Less Financially Beneficial to the Federal Government Than Many Think

As a report from Dobson-DaVanzo last year demonstrated, with the long ALJ delays, coupled with the 11% annual interest payable by the government on the amount the government recouped if the provider prevails, the actual yield to the government from the audits is greatly reduced, and perhaps close to being fully consumed by its costs. For example, RAC auditors receive something in range of a 13% bounty on whatever they claw back. If the case is reversed after the ALJ decision 4 years later, CMS would pay the 11%, which when compounded amounts to a 51.8% interest over the 4 years. In this scenario CMS may be able to secure the return of the RAC auditor commissions. Dobson-DaVanzo's work identified at least 58% of O&P RAC appeals are won at the ALJ level (this is the highest success rate among all provider subgroups, and could perhaps be higher, as only verified ALJ wins could be affirmatively identified)-this coupled with the above large interest due, would appear to largely obliterate any net long-term CMS gains from all the RAC efforts in O&P.

One concluding note is that two bills supported by AOPA would help alleviate some of the adverse impact of RAC audits on O&P professionals. S.829/H.R. 1530 would assure that CMS must recognize the orthotist/prosthetist notes of patient visits as a legitimate part of the medical record for purposes of determining medical necessity. H.R. 1526 would help reduce the cash flow devastation of audits and extended wait for appeals by establishing the maximum amount of recoupment that CMS could claw back **before** a final ALJ appeal decision to 50% of the contested amount until such time as HHS/CMS/OMHA are operating within the clear terms of the statute and assuring delivery of final ALJ decisions within the stated 90 days.

Contact Joseph McTernan with any questions at 571/431-0811 or jmcternan@aopanet.org.

Celebrate Health Professions Week for O&P!

How are you and your business celebrating Health Professions Week on September 26 – 30th? Post pictures on facebook and twitter to share how you celebrate. AOPA would like to sincerely thank all of those who work and volunteer in the health profession field, your contribution is appreciated and readily needed.

Contact Your Representative to Support the Medicare O&P Improvement Act

We need you help in urging support for S. 829/HR 1530: The Medicare O&P Improvements Act. This bi-partisan bill that provides common sense solutions to reduce fraud. AOPA Executive Director Tom Fise has been meeting with legislators on the Hill to urge their support, but they need to hear from constituents. Read the full bill here.

These are some of the provisions included in the bill:

- Requires Medicare to reimburse only those orthotic and prosthetic providers who are licensed (in states that require licensure) or accredited (applicable in all non-licensure states) to provide orthoses and prostheses
- Recognizes the value of the Orthotist's or Prosthetist's Notes in the Medical record;
- Assures due process rights to improve proper Administrative Law Judge (ALJ) time frames;
- Reinstates and clarifies the statutory definition of "Minimal Self Adjustment" for Off-the-Shelf Orthoses to protect Medicare beneficiaries;
- Distinguishes Orthotists and Prosthetists from Suppliers of Durable Medical Equipment (DME);
- Requires greater transparency and granularity in CMS data availability about audit outcomes.

Send a letter to Congress showing your support.

Jurisdiction D DME MAC Published Audit Results

Noridian Healthcare Solutions, LLC, who serves as the Jurisdiction D DME MAC, has recently released results of some of its ongoing pre-payment audits for O&P services. The published results include those related to spinal orthoses, knee orthoses, AFOs, and therapeutic shoes billed during the second quarter of 2016. Summaries of the audit findings are below:

Spinal Orthoses

Pre-payment review of spinal orthoses described by HCPCS codes L0631 and L0637 resulted in an overall error rate of 99%. Common reasons for denial included lack of documentation of the need for a custom fitted orthosis, improper proof of delivery documentation, and failure to respond to requests for additional documentation.

Knee Orthoses

Pre-payment review of knee orthoses described by HCPCS code L1833 resulted in an overall denial rate of 92%. Common reasons for denial included lack of objective documentation of knee instability, improper reporting of a correct diagnosis code, improper proof of delivery documentation, and failure to respond to requests for additional documentation.

AFOs

Pre-payment review of AFOs described by L1960 resulted in an overall denial rate of 73%. Pre-payment review of AFOs described by L1970 resulted in an overall denial rate of 78%. Pre-payment review of AFOs described by L4360 resulted in an overall denial rate of 98%. Common denial reasons included lack of documentation of a need for a custom device rather than a prefabricated device (L1960 and L1970), lack of documentation regarding modifications that were made to custom fit the device (L4360), failure to respond to requests for additional documentation, and no proof of delivery documentation.

Therapeutic Shoes

Pre-payment review of therapeutic shoe claims resulted in an overall denial rate of 76%. Common reasons for denial included lack of documentation from the certifying physician, lack of proof of an in-person fitting visit with the supplier of the shoes, and failure to respond to additional documentation requests.

The high denial rates for all of these pre-payment reviews mean that claims for these HCPCS codes will remain under pre-payment review going forward. It is important to remember that many of these denials may have been avoided by responding to requests for additional documentation or ensuring that proof of delivery documentation meets Medicare's published requirements.

Now Available: 2016 Operating Performance Report

AOPA Releases Results from Member Benchmarking Survey

Are you curious about how your O&P business is performing compared to others? Have you been asking 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?*

Copies of the **2016 Operating Performance Report** are now available. The annual report provides a comprehensive financial profile of the O&P industry including balance sheet, income statement and payer information organized by total revenue size, community size, and profitability. This year's data was submitted by more than 88 patient care companies representing 1,164 full time facilities and 71 part-time facilities.

For those wanting to learn more about using benchmarking data to strengthen their business, a seasoned panel of experts will present "The Top 5 Things to Know About Your Business to Survive and Succeed" at the 2016 Assembly in Boston on Friday September 9, 2016 from 4:00-5:00 PM. Current and historical operating performance data will also be used to illuminate trends taking place in the O&P industry.

2016 Operating Performance Reports are available electronically or print in AOPA's bookstore.
2016 Operating Performance Report (Electronic) member/nonmember $185/$325
2016 Operating Performance Report (Print) member/nonmember $285/$425

To order your copy, visit https://www.aopanetonline.org/store.

October 12 Webinar: KO Policy: The ABCs of the LCD and PA

Oct. 2016

12

1:00 PM Eastern

Cost

- $99 for AOPA Members/
- $199 for Non-Members
- (Members use promo code 'member')

Date

- Wed, September 14, 1:00 PM EST

Join AOPA for a one hour webinar and earn 1.5 CEs, while learning everything you need to know about appeals. During this webinar, an AOPA expert will answer these questions:

• Examine which addition codes can be used with each base code
• Determine what documentation is needed for each type of knee orthoses
• Determine when you may use the KX modifier on a KO claim
• Review all other pertinent information found in the LCD & Policy Article

REGISTER

Join the Coding & Billing Experts in Las Vegas!

The AOPA Coding & Billing Experts are Coming to Las Vegas!

AOPA's next Coding & Billing Seminar will be in Las Vegas! 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 November 14-15 in Las Vegas!

At this seminar you will:

- **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**

Register Now

Upcoming AOPA Events

October 12, 2016 — *KO Policy: The ABCs of the LCD and PA*
AOPA Webinar
Learn more and register here

November 9, 2016 — *Don't Miss Out: Are You Billing For Everything You Can?*
AOPA Webinar
Learn more and register here

November 14-15, 2016 — *Coding & Billing Seminar*
Las Vegas, NV
Learn more and register here