AOPA In Advance SmartBrief
Breaking News
September 20, 2018

AOPA Headlines:

RAC Audits for Custom Fabricated Knee Orthoses Announced

Performant Recovery, the national Home Health, Hospice, and DMEPOS RAC contractor, has announced that it will be initiating a post-payment complex medical review for custom fabricated knee orthoses (KO) described by HCPCS codes L1844 and L1846. Performant Recovery added the review to its list of approved issues on September 14, 2018. Providers whose claims are selected for review will receive a letter from Performant Recovery requesting relevant documentation to support medical necessity for the orthoses that was provided.

If you receive an additional documentation request (ADR) from Performant Recovery, it is very important to respond - failure to do so will result in automatic claim denial and recovery of any payments previously made. As with all RAC reviews, specific rules are in

place that limit the number of ADRs that O&P providers may receive to a maximum of 10 ADRs per Tax ID every 45 days, and the lookback period for reviews is three years.

The RAC audit for custom KOs is the third O&P specific approved issue since the award of the new RAC contract to Performant Recovery. The RAC announcement on the audit of custom KOs may be found by **clicking here** and searching for issue 0107.

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

AOPA Submits Comments Regarding Improving the Medicare Gap Filling Process

On September 10, 2018, AOPA submitted formal comments to CMS regarding suggestions on how to improve the "gap filling" process that is currently used to establish Medicare fee schedule amount for new HCPCS codes. The opportunity to provide comments was the result of the annual proposed rule regarding Medicare coverage of End Stage Renal Disease (ESRD) and DMEPOS competitive bidding. The proposed rule requested suggestions from interested parties on how to improve the gap filling process.

Gap filling is used to establish Medicare fee schedules for new HCPCS codes. Current statutory requirements mandate that when a new code is issued, CMS establishes a base price for the device, deflates the price to 1986-1987 rates by applying the annual consumer pricing index for urban areas (CPI-U) and then re-inflates it by applying the annual update to the Medicare O&P fee schedule. Since the O&P update has not always equaled the CPI-U, gap filling results in a slightly lower price than the base price that was established for the device.

The gap filling process has never been transparent and represents an archaic and outdated process that does not consider important factors such as professional service and clinical expertise when calculating Medicare fee schedules. AOPA welcomed the opportunity to provide comments and made several suggestions it believes will greatly improve the current system.

AOPA's comments may be viewed here.

Don't Miss this BOC Workshop at the AOPA National Assembly

BOC Standards and Compliance: The Bottom Line in Performance Improvement (Room 204)
Wayne R. Rosen, BOCP, BOCO, FAAOP, BOC Board Chair

Organizational performance improvement is an important and highly misunderstood topic. It is clearly mandated by CMS Quality Standards, but this workshop will help you understand why you should focus here not only for compliance, but also to enhance your ROI. Sponsored by BOC, this two-hour workshop focusing on standards and compliance explains how you can improve the overall performance of your practice by having

credentialed individuals on staff and provides a better understanding of what standards are applicable to your business. You will receive tips on how to get employees credentialed and how to maintain compliance. This workshop will be held on Wednesday, September 26 from 8:00 – 10:00 AM.

New Medicare ID Card Update

The new Medicare ID cards with a Medicare Beneficiary Identifier (MBI), instead of the Health Insurance Claim Number (HICN), are now being mailed to beneficiaries living in Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington and Wyoming.

Once beneficiaries receive their new MBI cards, they may start using them right away. You may continue to use either the HCIN or MBI through December 31, 2019.

O&P PAC Corner

The O&P PAC Corner provides information on the activities of the O&P PAC, including the names of individuals who have made recent donations to the O&P PAC and the names of candidates the O&P PAC has recently supported. We would like to thank the following AOPA member(s) for their recent contributions to the O&P PAC:

- David Boone, PhD
- Dan Luitjohan, CP
- Lesleigh Sisson, CFom

The purpose of the O&P PAC is to advocate for legislative or political interests at the federal level, which have an impact on the orthotic and prosthetic community. The O&P PAC achieves this goal by working closely with members of the House, Senate and other officials running for office to educate them about the issues, and help elect those individuals who support the orthotic and prosthetic community. To participate in, support, and receive additional information about the O&P PAC, please sign an O&P PAC Authorization card today. Please contact Devon Bernard at dbernard@AOPAnet.org.

Department of Veterans Affairs Office of Inspector General Issues a Report on VA Payments for Prosthetics

As many AOPA Members may already be aware, earlier this week, the Department of Veterans Affairs Office of Inspector General (VA OIG) issued a report regarding VA overpayments for prosthetic devices described by not otherwise classified (NOC) procedure codes. The full report may be accessed here.

The key paragraph in the report addresses purported overpayment by the VA to prosthetic providers of $7.7 million from October 2014 through July 2017. The paragraph reads as follows:

"The VA Office of Inspector General (OIG) substantiated allegations received in January and February 2016 alleging the Veterans Health Administration (VHA) was overpaying for prosthetic items because it incorrectly used Not Otherwise Classified (NOC) codes to classify the items for payment to vendors. Incorrectly using an NOC code can result in an overpayment because the payments are not based on pre-established reimbursement rates. For example, the Touch Bionics I-Limb, when classified with the correct code, costs VHA about $27,000. However, VHA paid vendors as much as $61,702 for the same item when classified using an NOC code. The OIG found that VHA overpaid vendors about $7.7 million from October 2014 through July 2017. The OIG found prosthetists incorrectly used NOC codes to classify prosthetic items when existing codes adequately described the items. Prosthetists incorrectly used NOC codes because they were either unaware of the existing codes or because they allowed vendors to classify the items with NOC codes. The incorrect use of NOC codes to classify some prosthetic items was not detected because the Prosthetic and Sensory Aids Service lacked a process to monitor the use of NOC codes. Because prosthetists incorrectly used NOC codes to classify prosthetic items for reimbursement, VHA paid more for the items. The OIG made five recommendations including determining which codes are appropriate to classify prosthetic items for reimbursement and issuing revised guidance, establishing an oversight and reporting structure that defines the roles and authorities to approve recommendations for the use of codes to classify specific prosthetic components, developing processes to monitor the use of NOC codes, and implementing processes to establish pricing guidance that ensures VA pays a fair price for items classified using an NOC code."

Fundamentally, The OIG's critique is based on the errant assumption that the Medicare code/HCPCS process and PDAC coding verifications are working appropriately. If that were true, the OIG conclusions in the report might be at least partially correct, but the assumption is false, and so the OIG criticism is wrong, missing the point. The situation reflected in the VA OIG report represents a clear, but unfortunate choice—will veteran amputees receive the high quality of care to which virtually everyone in America says they deserve or will their access to advanced technology be limited due to an outdated and ineffective coding system. If the VA had followed the limitations of the Medicare-based HCPCS coding system and product verification, it is exceedingly unlikely that amputee veterans would have gained access to, and the benefits of these new technologies. Knowing this, key leaders within the VA prosthetics leadership identified a way to make sure amputee veterans could receive these newer devices—by providers using the Not Otherwise Classified—NOC codes.

Below is a summary of why the CMS-based coding system, also generally used by the VA is broken.

Is the Coding Process/System, and the Related Assignment of Pricing for New Prosthetic and Orthotic Products, in Its Obsession to Reduce Costs, Serving as an Impediment to Investment in Innovative Technologies That Could Benefit Medicare Beneficiaries?

Research and development (R&D) for health care—whether in pharmaceuticals or in devices, represents a substantial capital commitment of resources. Companies commit to R&D based on their expectation that the increased benefits and value of new, improved technologies will be recognized via higher, justified pricing and reimbursement. If pricing is locked regardless of increases in value, companies and their investors will refrain from substantial resource

commitments that offer no return on the investment. This is a basic business concept and not hard to understand.

The group with proper authority for overseeing new code requests – Medicare's HCPCS Workgroup – presents profound challenges that severely discourage the introduction of new orthotic and prosthetic technology to market, and this disincentive is reinforced by an outdated pricing policy currently under examination. In an era of unparalleled technological innovation, where FDA records demonstrate that 98% of the new medical devices applications it processes are approved as to their safety and effectiveness, the number of applications to the HCPCS Coding Workgroup has *decreased*. Over the last 5 years, O&P manufacturers have submitted only 24 applications for new products, a nearly 50% decline when compared to the preceding 5 years (49 applications).

During the same 5-year period, the HCPCS Coding Workgroup has approved only two new O&P codes, one of which – a powered ankle-foot system for lower-extremity amputees – Medicare's contractors later designated as non-covered for all Medicare beneficiaries. This tells the story that only 4% of HCPCS code applications submitted over the last five years have resulted in a new device gaining access to Medicare beneficiaries, and less directly, to VA patients. These numbers suggest that the obstacles to both obtaining a code and maintaining coverage for it are stifling prosthetic and orthotic innovation.

Below are a few examples of significant new technologies where both patient access, and manufacturer return on investment have been severely hampered by regulatory actions that short-changed Medicare's recognition of significant advances because Coding and Pricing authorities were excessively locked into assuring that there be no increase in payment commensurate in any way with either increased value, or manufacturer R&D investment needed to bring the product to market.

1. Ossur Pro-Flex was introduced as a new, highly dynamic foot design. Yet, it was classified according to predicate products that shared its basic design features even though the performance characteristics of the new product were very different from the predicate products it was classified as being similar to.

2. Bionix, powered ankle/foot—a relatively new product, which was issued a new HCPCS code (L5969) but with an unreasonable reimbursement amount. After 4 months the DME MAC contractors indicated that there was "insufficient information to demonstrate that the item meets the Medicare standard to be considered reasonable and necessary" and that claims for L5969 will be denied as not reasonable and necessary. The Medicare fee schedule for this code was subsequently eliminated. A code without any Medicare allowable is not a viable code that anyone will use. After years of effort by the manufacturer, it appears this inequity may be poised to be addressed and rectified.

3. Genium knee (mentioned specifically in the OIG report)—the manufacturer did not seek a new code, planning to await some research and clinical results with the product. The DME MACs took the initiative to assert that the device was NOT experimental and assigned the new device the identical allowable reimbursement as the preceding "C-leg" device, despite significantly advanced

product performance largely attributable to advances in software—CMS has locked into hardware only, ignoring the valuable software advances that deliver better performance.

Turning to another dimension of coding and pricing policy for new orthotic and prosthetic technologies, the standards upon which the PDAC evaluates coding verification applications and the rationales underlying its decisions are not publicly available in any format. To the extent that industry experts can assess the reasoning behind the PDAC's coding decisions, they note that these determinations appear to rest only on the device's appearance not its performance characteristics, that is, what that same device actually *does* for the patients who need them[instead of whether it looks like the original 'predicate product, which may have been on the market for 30 years (does today's automobile *look* exactly like cars built 30 years ago, or *operate exactly the same way*?)]. As a result, prosthetic and orthotic manufacturers almost universally decline to voluntarily submit coding verification requests to the PDAC, a process which itself lacks transparency.

AOPA has tried for the past year to activate discussion, via a Roundtable or Joint Hearing whereby the House VA Health Subcommittee, and the House Ways & Means Health Subcommittee could gain a greater understanding of the many problems with the coding and product verification processes, and the adverse impact these can have on new product development and ultimately the adverse impact this has on both Medicare amputees, as well as amputee Veterans access to technology demonstrated in a recent report by the RAND Corporation to reduce serious falls, and death from falls by 450%.

The HCPCS coding system, and CMS coding verification are at best marginally functional, and at worst dysfunctional. We cannot address whether either the percent of the mark-ups or reimbursements paid that are mentioned in the VA OIG report were appropriate. What we can say, is that VA personnel, the VA Coding committee, and the private sector contractors who serve the amputee veteran community were faced with the dilemma of how to try to keep the care for amputee veterans current with new technology, and assure that veterans who had sacrificed a limb in the service of their country received timely access to improved mobility, despite the profound problems with the coding and product verification systems used by Medicare. Perhaps they could have done a better job, which may have saved the VHA money, but the steps these parties took did undoubtedly improve Veterans access to quality care, and improved mobility.

AOPA has been working, and will continue to work, with others, including the O&P Alliance and the HCPCS Coding Alliance to rectify these shortcomings. We' will continue to keep AOPA members informed on our progress. The AOPA VA Committee, chaired by Frank Snell, is actively engaged on this report, and will be discussing this further when they meet at the AOPA National Assembly in Vancouver in late September.

O&P News Special Announcement

The American Orthotic and Prosthetic Association (AOPA) continues its stride toward innovation by creating an online presentation and platform for O&P News. With an efficient website and click-ready flip-book, advertisers are more likely to garner viewership and gain exposure in the overall

health-care arena. As always, AOPA strives to provide the best resources and value for our members, as we continue to expand the scale of the publication and both the numbers and therapeutic breadth of its readership through this new platform.

As of September 2018, O&P News will no longer produce a print edition. We value our readership and acknowledge the demand of ready and quick access to the latest articles. You will have immediate digital access across all device platforms. Digital subscription is easy, just fill out the postcard with your email information featured in O&P News August 2018 issue. Or subscribe at *bit.ly/OPNSubscribe.* We are excited to expand our reach across all platforms and are thankful for all our readers!

Mission:

Educate and inform health professionals who serve the greater limb-loss community and those living with mobility challenges.

Distribution:

O&P News targets the extended community of health professionals serving individuals living with mobility challenges and is their connection to relevant news from the world of orthotics and prosthetics.

With electronic distribution cresting 20,000 and print subscriptions over 12,000, it is clear that the O&P News audience is interested in receiving the magazine electronically. Therefore, AOPA has decided to begin electronic publication only beginning September 2018. August 2018 will be the last print issue.

Each issue will continue to feature clinical insights from top minds in patient care, research summaries, product news, and more.

Advertisers:

Advertisers continue to express interest in an integrated advertising approach of print and digital ads. This can now be accomplished through the print platform of *O&P Almanac* and the digital platform of *O&P News.*

Advertisers will receive the added benefit of reaching a broader audience through advertisements in the magazine flip book as well as banner ads on the website and in the email distribution of the magazine. Get additional punch for your advertising investment through the greatly expanded breadth of readers and accountability of O&P News. Contact Bob Heiman at 856-673-4000 or *bob.rhmedia@comcast.net* to secure your placement!

Don't miss an issue! Subscribe today by returning the postcard included with this issue of O&P News or visit *bit.ly/OPNSubscribe*.

Spinal Bracing RFP Deadline is TODAY

AOPA, under the auspices of its Orthotics 2020 program, circulated a request for proposals early in 2018 relating to 5 subject areas for original orthotic papers, with the original deadline for receipt of applications by April 30, 2018. Proposals have been received in all five of those categories. This notification is to announce a **re–opening of the opportunity to submit grant applications/extension of the deadline for applications as to the two revised RFPs on spinal**

bracing (available below). Extensions do not apply to any of the other research categories/RFPs which have already advanced into the decision stage.
AOPA will now be accepting applications for grants as to the two revised spinal bracing RFPs, available below, provided that they are received no later than **September 20, 2018 at 11:59 pm**.

In all other respects, except for this extended deadline date, all terms stated in the original AOPA announcements remain intact and in effect as to these two revised spinal bracing RFPs.

Please review closely the terms of the RFPs. One problem we have noticed with responses is that there were multiple scoliosis applications/research protocols submitted under the RFP for back bracing. The category of back bracing is neither written nor intended to solicit submissions related to scoliosis. There may come a time when we will be looking for scoliosis papers, but this is NOT that time, so please do not commit your valuable time and energies to submitting scoliosis proposals in response to this back bracing RFP.

Back bracing is a very important and primary category in the orthotics profession. We have intentionally expanded the publication/notification /outreach to a broader audience of potential investigators toward submission of proposals as to these two revised spinal bracing RFPs. We will encourage and will welcome all high-quality submissions which are in accordance with the terms of the two RFPs.

2018 Clinical or Comparative Effectiveness RFP on Back Bracing and Factors on Favorable Patient Outcomes (FINAL 75)

2018 Clinical or Comparative Effectiveness RFP on Back Bracing and Factors on Favorable Patient Outcomes (S S-150)

Please contact AOPA staff at ymazur@AOPAnet.org with any questions.

Jurisdiction D Releases Quarterly TPE Results: Diabetic Shoes

Noridian, the Durable Medical Equipment Administrative Contractor (DME MAC) for Jurisdiction D, recently published the quarterly results of their Target, Probe & Educate (TPE) audits for Therapeutic Shoes for Persons with Diabetes. The audit results are based on claims for code A5500 reviewed during April 2018-June 2018 and they show an overall claim potential improper payment rate is **33%.**

The top denial reasons for the TPE results are:

- Documentation does not support basic coverage criteria
- Detailed Written Order (DWO) was not received
- Documentation was not received in response to the Additional Documentation Request (ADR) letter
- Medical record documentation was not received

View the complete results and a full list of denial reasons here.

Thank you to our Supplier Plus Members

Attend the Las Vegas Coding & Billing Seminar November 12-13

The Tropicana Las Vegas
3801 S Las Vegas Blvd
Las Vegas, NV 89109

AOPA experts provide the most up-to-date information to help O&P Practitioners and office billing staff learn how to code complex devices, including repairs and adjustments, through interactive discussions with AOPA experts, your colleagues, and much more. Meant for both practitioners and office staff, this advanced two-day event will feature breakout sessions for these two groups, to ensure concentration on material appropriate to each group.
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

September 26-29, 2018	AOPA National Assembly Vancouver, Canada Learn more and register here
October 10, 2018	*Year End Review: How to Wrap-Up & Get Ready for the New Year* AOPA Webinar Learn more and register here
November 4-10, 2018	*AOPA Healthcare Compliance & Ethic's Week* AOPA Sponsored Events Learn more here