American Orthotic & Prosthetic Association

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AOPA In Advance SmartBrief
Breaking News
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DME MACs Publish Revised "Dear Physician" Letter Regarding Documentation of Orthotic and Prosthetic Services

On November 13, 2018, the DME MACs published a revised Dear Physician letter that addresses the Medicare requirements for documentation within the referring physician's medical records that support the medical necessity of orthotic and prosthetic services provided to Medicare beneficiaries. This letter replaces an early Dear Physician letter, issued in August, 2011 that was retired earlier this year as a result of the passage of legislation which AOPA had promoted and lobbied for (Section 50402) that requires Medicare to consider the medical records of orthotists and prosthetists as a legitimate part of the medical record for purposes of claims payment and medical necessity review/determinations.

The newly released letter acknowledges the legislative change that was passed in February, 2018 and reminds physicians that while orthotist and prosthetists notes are now part of the patient's

medical record for purposes of medical necessity review, it emphasizes the continued need for referring physicians to document the medical need for the O&P devices they prescribe. The letter stresses that O&P practitioner notes must "corroborate and provide details consistent with the physician's records" and that conflicting information in the physician's notes and O&P practitioner notes may result in claim denial.

The letter continues on to discuss the importance of physician documentation of the patient's overall health to support their assigned functional level including symptoms limiting ambulation or dexterity, ambulatory assistance that the patient is using either in addition to their prosthesis or that they used prior to amputation, co-morbidities affecting ambulation and the ability to use a prosthesis, a summary of their activities of daily living, and a physical examination that is relevant to functional deficits. AOPA is encouraged by the continued acknowledgement of a patient's potential as a factor when establishing their appropriate functional level as well as the reminder that bilateral amputees cannot always be strictly bound by functional level classifications.

While the letter certainly is not perfect, AOPA is pleased that the DME MAC Medical Directors have acknowledged the legislative change that requires the recognition of O&P Practitioner notes as part of the medical record. As AOPA has reported in the past, the legislative change does not and was not intended to remove or diminish the role of the physician as a vital partner in the rehab team. In this respect, the legislation generally puts things on documentation back to where they stood in July, 2011 (before that Dear Physician sought to completely eliminate all consideration of the O&P professional's notes and records)—O&P clinical records are legitimate as consistent with, corroborative of, and fill in additional details in addition to the physician's prescription and clinical findings submitted to CMS. This matches with the intent of the legislation to acknowledge and recognize the role of the O&P practitioner as a health professional with valuable clinical input on the overall health and prosthetic needs of the Medicare beneficiary.

AOPA is quite concerned by this latest Dear Physician letter's assertion that prior and concurrent patient use of ambulatory aids (canes, walkers, crutches and wheelchairs) as in any sense a significant consideration in determining a patient's functional level, This was a central tenet of the July 2015 proposed Local Coverage Determination which was universally criticized by all 80+ witnesses at the public hearing (also for lack of any scientific justification), and which was rejected earlier this year by the CMS Interagency Workgroup's repudiation of that draft LCD, which also has since been 'retired.' Further, multiple scientific studies have shown that ambulatory aids are not necessarily an impediment to function and often improve a patient's ability to effectively use a prosthesis.

AOPA will review the revised Dear Physician letter and provide any concerns that it has to the DME MAC Medical Directors, and other Medicare authorities.

The revised Dear Physician letter may be viewed here.

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

2019 Medicare Part A & B Deductibles Premiums, & Coinsurance Amounts Released

The Centers for Medicare and Medicaid Services (CMS) has recently announced the Medicare premium and deductible rates for 2019. The monthly Medicare Part B premium will begin at $135.50. This is slightly higher than the 2018 amount of $134. The Medicare Part B deductible for

2019 has increased by $2 and will be set at $185.00; the Medicare Part B coinsurance remains at 20 percent of the Medicare allowed charge.

The Medicare Part A deductible for 2019 is set at $1,364 and the daily co-insurance amount for days 61-90 is $341 and the lifetime reserve day's rate is set at $682. Lastly, the SNF Part A extended care days co-insurance (day 21-100) will be $170.50 for 2019.

Amounts in Controversy for 2019 Released

Medicare recently released the Amounts in Controversy (AIC) for the 2019 calendar year. The AIC is the monetary threshold which must be met to file an appeal with the Administrative Law Judge (ALJ), third level of appeal, and with the Federal District Court, fifth level of appeal. The 2019 AIC for the ALJ is $160 and the AIC for the Federal District Court is $1,630. The new AICs will be effective for all appeal requests filed on or after January 1, 2019.

CMS Proposes OTS Spinal Orthoses and OTS Knee Orthoses as Product Categories for Next Round of Competitive Bidding

On November 1, 2018, the Centers for Medicare and Medicaid Services (CMS) announced that it is soliciting comments on its proposed inclusion of off-the-shelf spinal orthoses and off-the-shelf knee orthoses as product categories in the next round of Medicare competitive bidding. This announcement came on the same day that the final rule on changes to the competitive bidding program was announced. Ironically, a provision of the final rule was the announcement of a delay in the implementation of future rounds of competitive bidding until at least January 1, 2021. While the impact of inclusion of OTS spinal and knee orthoses will not be felt for at least two years, the recent CMS announcement represents the first indication that OTS orthoses of any kind will be included in competitive bidding.

There is a total of 16 OTS spinal orthoses and 8 OTS knee orthoses that have been identified for inclusion in the competitive bidding program. AOPA has performed preliminary analysis on the codes included in the proposal and traditional O&P providers are responsible for less than 15% of overall claims submitted to Medicare for the codes in question. While these codes do not represent a large portion of a typical O&P practices business, AOPA continues to believe that no orthoses should be subject to competitive bidding and will be submitting comments to CMS indicating that competitive bidding for OTS orthoses is not in the best interest of patients or the Medicare program. The CMS announcement may be viewed here. Comments must be submitted by December 3, 2018.

HCPCS Code Changes for 2019

The Centers for Medicare and Medicaid Services (CMS) has released the new Healthcare Common Procedure Coding System (HCPCS) codes for 2019, and there were a few minor changes. Below is a complete breakdown of the code changes which will be effective for claims with a date of service on or after January 1, 2019.

New Codes

Code	Descriptor

A5514	For diabetics only, multiple density inserts, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated

Changes in Code Descriptors

Code	New Descriptor	Old Descriptor
A5513	For diabetics only, multiple density inserts, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer **(**or higher**)**, includes arch filler and other shaping material, custom fabricated, each	For diabetics only, multiple density inserts, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

The change in the descriptor is a minor grammatical change, and not an actual change in the code verbiage. The new descriptor places parenthesis around the phrase or higher. The change makes the descriptor in line with the verbiage of the A5512 and the new A5514.

Deleted Codes

Code	Descriptor
K0903	For diabetics only, multiple density inserts, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each

The temporary K code, K0903, which has been active since April 1, 2018 has been deleted and will be cross walked to the newly created A5514 code.

AOPA's Coding and Reimbursement Committee will review the list of changes and provide appropriate comments to CMS.

As a reminder registration is still open for the December 12, 2018 AOPAversity webinar (New Codes, Medicare Changes & Updates), which will focus on the changes to the HCPCS code set and any other upcoming Medicare changes which may impact your business in 2019.

Questions regarding the code changes may be directed to Joe McTernan at jmcternan@**AOPA**net.org or Devon Bernard at dbernard@AOPAnet.org.

Thank you to our Supplier Plus Members

CMS Releases Final Rule on DMEPOS Competitive Bidding and Potential Changes to Gap Filling Methodology

On November 1, 2018 the Centers for Medicare and Medicaid Services (CMS) published a final rule that addressed changes to the DMEPOS Competitive Bidding program and potential changes to the gap filling methodology that is currently used to establish Medicare fee schedules for new HCPCS codes.

The final rule followed a proposed rule that was published on July 11, 2018. AOPA submitted comments on the proposed rule on September 10, 2018. The competitive bidding and gap filling provisions addressed in the final rule are part of the larger final rule entitled, "*Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) and Fee Schedule Amounts, and Technical Amendments to Correct Existing Regulations Related to the CBP for Certain DMEPOS*". This is a rule that is published annually to update the Prospective Payment system for the Medicare prospective payment system for the Medicare End Stage Renal Disease program but has also been used to announce changes to the DMEPOS competitive bidding program.

The final rule confirmed that there will be at least a two year pause in the Medicare DMEPOS competitive bidding program while the provisions of the final rule are implemented, and new

contract proposals are solicited and evaluated for award. In the final rule, CMS does not expect the next round of competitive bidding to begin prior to January 1, 2021.

The provision of the proposed rule that is of greater immediate interest to AOPA members is one that requested input on improving the gap filling methodology that is currently used to establish Medicare fee schedule amounts for new HCPCS codes. In the proposed rule, CMS announced that it was soliciting comments on how to improve the gap filling process. In its comments, AOPA recommended that the gap filling process must be completely transparent and must be modernized to include accurate resources when establishing Medicare fees. While CMS received significant comments on the gap filling process, it declined to initiate any changes to the gap filling process as part of the final rule. The final rule only acknowledged the comments on the gap filling process and indicated that it would consider the recommendations that were submitted.
AOPA will continue to communicate with CMS regarding ways to improve the gap filling process and will report any changes to AOPA members.

DME MACs Announce a Minor Revision to the LCD for Lower Limb Prostheses

On November 1, 2018, the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs) released an updated Local Coverage Determination (LCD) for lower limb prostheses. Since the changes to the LCD were minimal and do not restrict coverage, the notice and comment period required by the 21st Century Cures Act does not apply to this revision.

The only change to the LCD was the removal of the patient weight range (110 lbs to 275 lbs) for coverage of L5859--Addition to lower extremity prosthesis, endoskeletal knee shin system, powered and programmable flexion/extension assist control, includes any type motor(s). All other requirements for coverage of L5859 remain the same.

AOPA continually reviews the Medicare LCDs and Policy Articles for changes such as this and will keep you informed when they occur.

AOPA 2019 National Assembly Call for Papers

The AOPA National Assembly Clinical Sessions Workgroup has issued a call for papers for the 102nd Annual AOPA National Assembly to be held September 25-28, 2019 in San Diego, California. The submission deadline is March 25, 2019. Share your expertise and advance your career by being part of the country's longest serving and largest meeting for the orthotic, prosthetic and pedorthic profession.

- Papers are being accepted for podium, poster and/or symposium sessions for each of the five concurrent education tracks (orthotic, prosthetic, pedorthic, technician, and business). For more information or to submit a paper go to our dedicated web page http://www.aopanet.org/education/2019-aopa-national-assembly/call-for-papers/
- All submission must be submitted electronically.
- Before submitting a paper, please review the model abstract which also provides additional information about the submission process. The model abstract is available at http://www.aopanet.org/wp-content/uploads/2018/10/National-Assembly-Abstract-Template-Model-1.pdf

For general information about the Assembly
Visit: http://www.aopanet.org/education/2019-aopa-national-assembly/
Email: Assembly@AOPAnet.org or call Ryan Gleeson at (571) 431-0836.

CMS Introduces New Documentation Look-Up Service Initiative

The Centers for Medicare and Medicaid Services held a special Open-Door Forum conference call on Tuesday, October 23, 2018, to educate the public about a new initiative tasked with developing an online resource where providers and suppliers can look up the documentation requirements necessary for Medicare to cover a service or item.

The goals of the Documentation Requirement Lookup Service prototype are to reduce provider burden, reduce improper payments and appeals, and improve "provider to payer" information exchange. CMS is currently recruiting providers and suppliers to pilot the prototype system. The initial pilot project will be populated with the following information:

1. If Medicare FFS requires prior authorization for a given item or service; and
2. Documentation requirements for Oxygen and Continuous Positive Airway Pressure Devices.

The slide presentation from the conference call can be accessed here.
Additional information about the Documentation Requirement Lookup Service Initiative can be found here.

AOPA Board Addresses and Provides Guidance on Issues of Non-Discrimination and Anti-Harassment in the Workplace

At its most recent meeting on September 24 at the AOPA National Assembly in Vancouver, the AOPA Board unanimously adopted the following statement, and determined to both include this in *AOPA Code of Interactions with Health Care Professionals,* and to recommend it to all AOPA Members (educational programming in support of this statement is being considered):

Nondiscrimination/Anti-Harassment in the Workplace
AOPA member companies, as assembled groups of healthcare professionals, must operate in full compliance with all federal and state laws, including those that govern discriminatory practices. Title VII of the Civil Rights Act of 1964 prohibits employers from discriminating against employees on the basis of sex, race, color, national origin, and religion. By way of accreditation, it is established that O&P facility owners operate with compliance plans that adhere to these tenets and condemn any form of discriminatory practices in the workplace. *Every employee is entitled to fair treatment in the workplace.* Any violation of these conditions is not consistent with the standing of AOPA member companies as assembled groups of healthcare professionals and is not consistent with this Code. More importantly, any violation of these conditions is almost certainly illegal, and punishable under state or federal laws.

AOPA also provided input on this issue to the O&P Alliance at its meeting in Vancouver which resulted in establishment of an Alliance Work Group on this item. AOPA has since submitted suggested language for an open letter from the O&P Alliance.

2019 AOPA Webinars Announced

AOPA is pleased to announce the topics for its 2019 Webinars, which take place on the second Wednesday of each month at 1:00 P.M. Eastern Time. Register here.

January 9: Understanding the Knee Orthoses Policy
February 13: Patient Outcomes: Best Practices & How to Use Them
March 13: Advanced Beneficiary Notice: Get to Know the ABN Form
April 10: Shoes, External Breast Prostheses, Surgical Dressings and Other Policies
May 8: Are You Compliant-Know the Supplier Standards
June 12: Documentation-Understanding Your Role
July 10: T.P.E – Get to Know the Program & What the Results are Telling You
August 14: Are You Ready for the Worst: Contingency Planning
September 11: Veteran Affairs Updates: Contracting, Special Reports and Other News
October 9: Performance Reviews: How is Your Staff Doing?
November 13: The Holiday Season-How to Provide Compliant Gifts
December 11: New Codes for 2020, Other Updates and Yearly Round-Up

Sign up for the entire series and get two conferences FREE. Entire Series ($990 Members/$1,990 Non-Members). Register here.

Upcoming AOPA Events

December 12, 2018	*New Codes, Medicare Changes & Updates* AOPA Webinar Learn more and register here
January 4-6, 2019	AOPA Leadership Conference Scottsdale, Arizona Learn more here
January 8, 2019	*Understanding the Knee Orthoses Policy* AOPA Webinar Learn more and register here
March 25, 2019	*Call for Papers Deadline* AOPA National Assembly Learn more submit here