American Orthotic & Prosthetic Association

AOPA in Advance

Breaking News for O&P Professionals

November 1, 2011 Volume 15, Number 22

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Newsletter Feedback

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O&P NEWS

2012 HCPCS Codes Released

The Centers for Medicare and Medicaid Services (CMS) has released the new HCPCS codes for 2012. There were a few changes to the codes that describe orthotics and prosthetics. A total of seventeen "L" codes were deleted, most of which described various mobile arm supports for wheelchairs, three new "L" codes were added and five "L" codes had their descriptors changed .

Click here to see the complete list of additions, deletions, and changes for 2012.

AOPA's Coding and Reimbursement Committee will review the list of changes and provide appropriate comments to CMS. Additionally, the 2012 code changes will be discussed in-depth during the December 14, 2011 **AOPA**versity Audio Conference. To register for this audio conference, please contact Stephen Custer at scuster@**AOPA**net.org.

Questions regarding the code changes may be directed to Joe McTernan at jmcternan@**AOPA**net.org or (571) 431-0811, or Devon Bernard at **dbernard@AOPAnet.org** or (571) 431-0854.

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Medicare Shared Savings Program and Accountable Care Organization Final Rule Released October 20, Published in Federal Register November 2

The final rule for the Medicare Shared Savings Program and Accountable Care Organizations spans 696 pages so concisely summarizing the rule presents a real challenge. Rather, we are highlighting the major changes made in the final rule from the proposed rule. As previously indicated, it is **AOPA**'s view that very few, if any, O&P patient care facilities will be in a position to seek recognition by CMS as an accountable care organization. However, we believe you will want to be generally familiar with ACO objectives and policies in the event that you are affiliated with a hospital or other provider group whose decision to seek ACO status affects aspects of your operation. Please note that while CMS made numerous changes to make the final rule more attractive it is still important to carefully consider potential benefits and risks in participating in an ACO as a provider/supplier. One area to pay particular attention to as an ACO participant is the proposed method of distribution by the ACO of any shared savings.

Section 3022 of the Affordable Care Act requires the Secretary to establish the Medicare Shared Savings Program (Shared Savings Program), which is intended to encourage the development of Accountable Care Organizations (ACOs) in Medicare. This program is also intended to promote accountability for a patient population and coordinate items and services under Medicare parts A and B, and encourage investing in infrastructure and redesigned care processes for high quality and efficient service delivery. CMS states that there are three primary aims of the Shared Savings Program: (1) better care for individuals, (2) better health for populations, and (3) lower cost growth through improvements in care.

CMS published the Medicare Shared Savings Program and Accountable Care Organizations proposed rule (proposed rule) on April 7, 2011. The Medicare Shared Savings program is a voluntary program in which interested participants must apply for acceptance into the Program. As a quick refresher the basic premise of the proposed Medicare Shared Savings Program is that certain organizations and providers may apply to be Accountable Care Organizations, which are legal entities responsible for the cost and quality of care for certain assigned Medicare beneficiaries. To participate in the Shared Savings Program the ACO must enter into a three-year agreement with CMS. CMS will assign a benchmark amount of expected expenses for the ACO's assigned beneficiaries. Even though

assigned to an ACO for purposes of this program the assigned Medicare beneficiaries are not required to receive their medical care through the ACO. For certain savings generated, by keeping expenses for the assigned beneficiaries below the benchmark amount, the ACO will be eligible to share in those savings with CMS. The ACO will also be required to meet certain quality and performance measures before being eligible for payment of shared savings. The amount of savings the ACO is eligible for depends on what track the ACO pursues. The two proposed tracks vary on the amount of shared savings available and the level of risk involved. Under the proposed rule Track one is a lower-risk model and does not require that the ACO share in the risk of loss until year three. Greater shared savings are available under Track Two where, if the cost for the assigned beneficiaries exceeds the benchmark amount, the ACO shares in the risk/loss beyond the benchmark beginning in the first performance year. There are also issues relating to Civil Monetary Penalties, Federal Anti-kickback Statute and the Physician Self-Referral Law.

Click here for AOPA's summary of the April 7 proposed rule.

CMS received substantial input from stakeholders, approximately 1,320 public comments, in response to the proposed rule and indicated in the Medicare Shared Savings Program and Accountable Care Organizations Final Rule (final rule) released October 20, 2011, that certain changes were made in an attempt to address stakeholder concerns. **Click here to read the final rule.**

The most notable changes to the proposed rule that are found in the Final Rule are as follows:

1. The previously proposed lower risk Track One required participants to share the risk of losses in year three, i.e. convert to a two-sided risk model. The final rule removes this requirement from Track One such that participants, who choose Track One, operate as a one-sided model for their initial agreement period and do not have to share in the risk of loss at all. However, the ACO may not use Track One for any subsequent agreement periods.

2. The method of assigning beneficiaries to an ACO will no longer be retrospective. Rather, beneficiaries will be assigned based on a two-step process. First there will be a preliminary prospective assignment where beneficiaries will be identified each quarter. Then, after every performance year there will be a final reconciliation that is contingent on the patients actually served by the ACO.

3. The number of quality measures proposed to assess quality was reduced from 65 measures in 5 domains to 33 measures in 4 domains in an effort to streamline the process. The measures will also be phased-in over a longer period of time, for example, the first year will include pay for reporting and the second and third years will include pay for reporting and performance under the measures.

4. All ACOs, both the one-sided risk model and two-sided risk model will share on first dollar over the benchmark once the required minimum savings rate is reached. Previously, in the proposed rule the one-sided risk model required that the ACO meet the minimum savings rate (2% savings over the benchmark) and the savings the ACO would be eligible to receive payments on would not include that initial 2% savings required as a minimum savings rate.

5. CMS will no longer withhold the first 25% of shared savings payments from ACOs. Previously, CMS proposed withholding this amount from the ACO until completion of the three year agreement. Also the shared savings cap was increased to allow the opportunity for ACOs the potential to obtain greater shared savings.

6. Previously, the ability of the ACO to share beneficiary claim data was restricted only to those beneficiaries that are seen by an ACO primary care physician within a performance year and do not object to data sharing at that time. The new rule allows the ACO to proactively contact beneficiaries from the quarterly list of assigned beneficiaries to inform those beneficiaries about data sharing and provide the beneficiaries the opportunity to object to data sharing if desired.

7. CMS added that certain critical access hospitals, Federally Qualified Health Centers and Rural Health clinics as eligible to both participate and form ACOs independently.

8. There is no longer a uniform annual start date required for ACO agreement. The Program will be established in January 2012 and the initial round of applications will be due early 2012. The first ACO agreements are to start 4/1/2012 and 7/1/2012, with the first performance year lasting 21 months and 18 months respectively.

9. Beneficiary reports will be provided more frequently than yearly, now additional reports to be provided quarterly. These reports are intended to help an ACO monitor the care the assigned beneficiaries receive both inside and outside the ACO.

10. Previously 50% of primary care physicians were required to be considered "meaningful users" of electronic health records by the start of the second performance year for each ACO. Now, this requirement is no longer being applied. However, EHR is part for the quality measures and will be weighted twice that of any other measure for quality-scoring purposes and for determining compliance with quality performance requirements.

11. Change in Marketing Guidelines. Rather than being required to wait for approval from CMS for use of marketing materials the final rule proposes that ACOs may use marketing material 5 days after the material is submitted to CMS if the ACO certifies compliance with marketing guidelines and CMS does not disapprove the materials or activities.

Applications for the Shared Savings Program by interested participants will be accepted beginning January 1, 2012.

We hope you found this summary of important changes to the Medicare Shared Savings Program useful.

For a more in-depth analysis of the ACO Final Rule please click on the following link to access a comprehensive slide presentation created by AOPA's lobbying and policy consultant Alston & Bird.

Questions? Contact Catherine Graf at cgraf@**AOPA**net.org or (571) 431-0807.

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CMS Innovation Center Notice of Advance Payment Model for Medicare Shared Savings Program Accountable Care Organizations

As part of stakeholder feedback on CMS' April 7th proposed rule on the Medicare Shared Savings Program and Accountable Care Organizations the concern was raised regarding the large amount of start-up capital that creating an accountable care organization (ACO) would require and how this would limit the ability of some interested participants in becoming an ACO. As part of the response to the concern the CMS Innovation Center is testing an Advance Payment Model. The stated goal of the Advance Payment Model is to test whether and how prepayment could increase participation in the Medicare Shared Savings Program and if the advance payments increase the rate at which an ACO can effectively coordinate care to generate Medicare savings. The Advance Payment Model is designed for certain eligible participants of the Medicare Shared Savings Program and allows for prepayment of expected shared savings that will later be recouped from earned shared savings. If there is a remaining balance of advance payments after the ACO's completion of the initial agreement period CMS will not pursuing collection that balance. However, if the ACO does not complete the entire agreement period then CMS will pursue recoupment of any remaining balance of advance payments.

The Advance Payment Model will provide for three types of payments:

- *An upfront, fixed payment*: Each ACO will receive a fixed payment.

- *An upfront, variable payment*: Each ACO will receive a payment based on the number of its historically-assigned beneficiaries.
- *A monthly payment of varying amount depending on the size of the ACO*: Each ACO will receive a monthly payment based on the number of its historically-assigned beneficiaries

Additionally, only two types of ACOs will be eligible:

- ACOs that do not include any inpatient facilities AND have less than $50 million in total annual revenue.
- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than $80 million in total annual revenue.

Any ACOs that are co-owned by a health plan are ineligible for the Advance Payment Model, even if those ACOs fall under one of the two categories above. Further, the Advance Payment Model is only being offered to eligible ACOs participating in the Medicare Shared Savings Program for the April 2012 and July 2012 start dates.

To participate in the program interested participants must apply to the Medicare Shared Savings Program as an ACO and also separately apply for the Advance Payment Model.

Click here for further information on the Advance Payment Model.

Questions? Contact Catherine Graf at cgraf@**AOPA**net.org or (571) 431-0807.

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UPDATE: AOPA and AC Meet with HHS after Institute of Medicine's Release of Recommendations on Defining Essential Health Benefits Package

As ***AOPA** in Advance* reported in the October 18 edition, after the October 7 release of the Institute of Medicine's (IOM) long-awaited report to HHS, **AOPA** participated in a public listening session on October 18 with HHS officials,including some those who **AOPA** met with on August 4. **AOPA** afforded itself of this opportunity for the purpose of clarifying some vague and broad comments in the IOM report about orthotics in a statement by **AOPA** Executive Director Tom Fise.

Click here to read the first part of the statement given to HHS.

Click here to read the comments AOPA submitted on definitions of O&P coverage.

In the meeting **AOPA** offered arguments about distinguishing customized orthopedic bracing from items such as wrist bands, shoe inserts, and DME. Education on this topic of customized orthoses included entering into the official record examples provided by **AOPA** President Tom DiBello, CO, FAAOP, that explain the difference between a basic over the counter product that could be bought at a pharmacy from the types of customized orthoses (from shoe inserts to customized bracing) provided for the long-term care of patients with chronic diseases and limb impairment and potential detirment to patients if the more sophisticated devices were not available to patients.

In attendance of the meeting were three HHS decision-makers, including Nancy DeLew, Associate Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation, who met with **AOPA** on August 4. O&P representatives included **AOPA** Executive Director Tom Fise, the O&P Alliance General Counsel Peter Thomas, and AAOP Executive Director Peter Rosenstein.

The meeting was productive as Tom Fise indicated that the key decision-makers in attendance understood the arguments being made to better differentiate orthotics in terms of customized orthopedic bracing for patients with limb impairment arising from chronic health conditions, e.g. MS, cerebral palsy, and spina bifida. of O&P.

On October 20, Dan Ignaszewski of The Amputee Coalition participated in another meeting with HHS that included many of the same personnel that have been present for prior O&P-related meetings. As Mr. Ignaszewski describes, the meeting was "an opportunity for the Amputee Coalition and other consumer advocacy groups to discuss concerns and make recommendations on the Essential Health Benefit (EHB) package in the Affordable Care Act (ACA) and the Institute of Medicine's (IOM) report that came out earlier this month on Essential Health Benefits (EHB)." Mr. Ignaszewski also explained that he took this opportunity with HHS to reinforce the need for prosthetics and custom orthotics to be included as essential health benefits by stressing the following points:

> "[that] the IOM report stated that 86% of insurance plans provide coverage for O&P which makes it widely covered; Twenty states that have passed laws mandating specific coverage; Independent studies have been commissioned in several of those states which have shown the benefits outweigh the costs; and In the case of Colorado, the state study actually showed a cost savings to the state. This was particularly helpful with HHS's and IOM's recommendation in balancing coverage and cost."

AOPA will continue to create, and take advantage of, opportunities to re-enforce these appeals for O&P's inclusion in the essential health benefits package and keep members apprised of those meetings.

Questions? Contact Steven Rybicki at srybicki@**AOPA**net.org or (571) 431-0835.

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Attention Supplier Members: Join AOPA for a Special Conference Call on November 9

The list of critical regulatory and legislative issues affecting **AOPA** Supplier Members has expanded dramatically in a brief period of time. The passage of the Affordable Care Act has been a prime factor. Please join us for a conference call update on these issues just for **AOPA** supplier members at 3:00 PM Eastern Time, Wednesday, November 9, 2011.

AOPA President, Tom DiBello, CO, FAAOP and Executive Director, Tom Fise, JD will host and lead the discussion. There will be an opportunity for a question and answer period so we can make sure all of your concerns are covered.

Please RSVP to scuster@**AOPA**net.org by November 4 and all who RSVP will be sent call in information and the agenda on Monday, November 9.

Questions? Contact Stephen Custer at scuster@**AOPA**net.org or call (571) 431-0876.

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Attention All AOPA Members: Be on the Look-Out for Three Pieces of Mail from AOPA

In the past two weeks **AOPA** has sent to all members the following information:

1. Executive Director Letter on Essential Benefits - a must read!
2. 3rd Quarter Staff Report - How **AOPA** is using your resources.
3. Your 2012 Membership Renewal Invoice - so we can continue serving you!

All three are important with #1 and #2 our continuing commitment to keep you informed about our efforts on your behalf, And of course the Membership Renewal is important so we can continue the services and advocacy to the O&P community and you especially. Each of these items will come to you separately within a few days of each other.

Questions? Contact Steven Rybicki at srybicki@**AOPA**net.org or (571) 431-0835.

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HIPPA 5010: Transition Deadline Approaching

In less than 60 days, all HIPAA covered entities (suppliers, health plans, clearinghouses, billing services, etc.) will be required to use the new HIPAA 5010 format for all HIPAA covered electronic transactions (claims submissions, remittance notices, claim status requests, etc.). If you do not make the switch to the HIPAA 5010 format before January 1, 2012, you will experience delays in processing your claims with both Medicare and private payers, as the current 4010 format will not be accepted after January 1, 2012.

Questions? Contact Devon Bernard at dbernard@**AOPA**net.org or (571) 431-0854, or Joe McTernan at jmcternan@**AOPA**net.org or (571) 431-0811.

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Register for AOPA's November 9 Audio Conference: "Happy Holidays! Kickbacks and Gifts in O&P"

As the holiday season approaches, Join **AOPA** for an **AOPA**versity Mastering Medicare Audio Conference that will focus on the question about gifts to referral sources resurfaces. Medicare has very specific rules about what you can and cannot do. Join **AOPA** for a November 9 audio conference entitled "Happy Holidays: Gifts and Kickbacks in O&P". Highlights of this 1 hour audio conference include:

- When gifts to referral sources are acceptable
- When gifts to patience are acceptable
- Federal Anti-Kickback regulation prohibitions
- Doing something nice vs. doing something illegal

The audio conference beings at 1 PM (EST), the cost of participating is $99 per line for **AOPA** members ($199 for non-menbers), and any number of employees may listen on a given line. Listeners can earn 1.5 continuing education credits by returning the provided quiz within 30 days and scoring at least 80 percent. Contact Devon Bernard at dbernard@**AOPA**net.org or (571) 431-0854 with content questions.

Click here to register online.

Questions? Contact Stephen Custer at scuster@**AOPA**net.org (571) 431-0876.

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O&P RESOURCES FROM AOPA

Check Out the AOPA Job Board for New Opportunities in O&P

If you need a position filled at your business or are interested in looking at other job possibilities within the O&P field, check out the **AOPA Online Job Board**. The online job board sports a freshly updated look and an easy-to-navigate profile creation system.

And remember: if you advertise on the Online Job Board and decide to also advertise in the *O&P Almanac*, then you'll receive a 5 percent discount on the cost of advertising in the *Almanac* and on the Job Board.

Questions? Contact Steven Rybicki at srybicki@**AOPA**net.org or (571) 431-0835.

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The 2011 Audio Conference Series from AOPA

Numerous offices have benefited from their participation in **AOPA**'s Medicare Audio Conferences. These one hour sessions come to you in the comfort of your office on the second Wednesday of each month at 1:00 PM Eastern. This series provides an outstanding opportunity for you and your staff to stay abreast of the latest hot topics in O&P, as well as gain clarification and ask questions on topics that you may not understand as fully as you would like to.

Seminars are still priced at just $99 per line for members ($199 for non-members). Buy the series and get two free; members pay just $990 and non-members pay $1990. If you purchase all the conferences, all conferences from months prior to your purchase of the set will be sent to you as CDs.

These convenient one-hour telephone seminars are designed to fit easily into your busy schedule. Any practitioners needing credit can get 1.5 per audio conference by returning the provided quiz within 30 days and scoring at least 80%. Billing staff and others who don't need credit can nonetheless gain information they will use right away. The topics for 2011 are:

- January 12: How to Meet the New Medicare Supplier Standards (Available on CD)
- Feb. 9: Using the Lower Limb Medical Policy to Your Advantage (Available on CD)
- March 9: Enhance Your Claims Success, Two Letters at a Time (Available on CD)
- April 13: Improving Clinical Documentation (Available on CD)
- May 11: Which Box to Check? The Negative Effect of the 855S on Reimbursement (Available on CD)
- June 8: Preventing Audit Disasters (Available on CD)
- July 13: Don't Rile the OSHA Police (Available on CD)
- August 10: How to Get Paid for Miscellaneous and Repair Codes (Available on CD)

- September 14: Don't Run Afoul of the KO Rules (Available on CD)
- October 12: Developing Your Medicare Billing Compliance Plan (Available on CD)
- November 9: Happy Holidays: Kickbacks and Gifts in O&P
- December 14: Are You Ready for the New Year? 2012 New Codes and Policies

Click here to register for any 2011 Audio Conference.

If you miss an audio conference, it will be available on CD after the fact. Cost is the same as if you participate live ($99/$199). We hope you'll be able to join us for this year's series.

Questions? Contact Stephen Custer at scuster@**AOPA**net.org (571) 431-0876.

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O&P INSIDER'S TRACK

The Only Up-to-the Minute O&P Newsline

People in the News

The **Amputee Coalition** announced that **Jeff Cain, MD**, a member of the Amputee Coalition's Board of Directors has been chosen as president-elect of the American Academy of Family Physicians (AAFP). The AC also announced that the family of the late **Kathy Spozio**, an Amputee Coalition Board member and activist, presented a gift of $4,500 to the Bridge to Ability Scholarship Fund, a program that provides new amputees the financial means to attend and enjoy all the benefits of the Amputee Coalition's national conference.

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Businesses in the News

OPAF and the First Clinics announced that McKeever's First ride was held at the Winslow Therapeutic Riding Center. Additionally, OPAF announced that **Ability Prosthetics & Orthotics** sponsored a First Swim Clinic in Charlotte, North Carolina.

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Send Us Your News!

The next ***AOPA*** *in Advance* will arrive in your inbox on November 15. So if you have a new employee or a new office, tell us! Share your news with the over 15,000 readers of the *O&P Almanac* and ***AOPA*** *In Advance* newsletter. Contact Steven Rybicki at srybicki@**AOPA**net.org

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