AOPA In Advance SmartBrief
Breaking News
March 15, 2018

AOPA Headlines:

AOPA Secures an Advocacy Victory on Reimbursement for Custom Fabricated, Direct Milled Diabetic Inserts

AOPA is very pleased to announce an advocacy win regarding the fee structure for K0903/A5513. AOPA has confirmed with the Centers for Medicare and Medicaid Services (CMS) that the Medicare fee schedule for K0903, a temporary HCPCS code, effective April 1, 2018, that describes custom fabricated, direct milled diabetic inserts has been set at the same amount as the current Medicare fee schedule for A5513 ($43.56 for most states), which describes custom fabricated diabetic inserts that are fabricated over a positive model of the patient's foot. This has been a very long battle, one in which AOPA partnered with the American Podiatric Medical Association, the O&P Alliance, and the Amputee Coalition. AOPA is also greatly indebted to Rep. Brad Wenstrup and his excellent staffers - Derek Harley, Nick Uehlecke (Ways & Means Committee) and Greg Brooks for their help, as well as Joe McTernan, Devon Bernard, Ashlie White and others on AOPA's lobbying team. Believe it or not, this battle started in August, 2017, when we set our strategy, began outreach to podiatrists, and to key Hill players! This is VERY important because A5513 is not the only code where scanning processes have evolved - this hopefully sets the right precedent for the agency.

This battle included a decision, first highlighted by PDAC, that diabetic shoes inserts that were fabricated using scanning devices and direct milling did not meet the precise words of the A5513 code, which referenced the process as molded over a model of the patient's foot. A coding verification notification was initiated by PDAC to focus on the process used. It should be noted that this code, vital to protecting diabetic patients, had declined in utilization by 14% in the prior 3 years, largely because of unreasonable reimbursement cuts. At an Open Door Forum, CMS announced that they agreed that the processes were equivalent, but also said that the scanned device required less work, and they expected to reduce the fee by about $7 for direct milled inserts. A long battle has ensued, where as a result of Congressional pressure, the fee decision was shifted to the very highest levels in CMS. Ultimately, CMS reached the right decision that as the processes were essentially equivalent, the fee needed to also be identical (one of the several arguments AOPA mounted was the CMS' own manuals say that when one code is "exploded" into two parallel codes both new codes must retain the same fee), as provided in CMS' own Medicare Claims Processing Manual.

AOPA is proud of this advocacy victory, not only for what it represents for providers of diabetic inserts, but also for the precedent that it sets for future issues involving the use of scanning and other technology to create alternate manufacturing processes in orthotics and prosthetics.

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

AOPA Submits Comments on Proposed Rule that Would Impact Coverage of Essential Health Benefits

On March 6, 2018, AOPA submitted comments on a proposed rule that would change the definition of the term “employer” as it relates to association health plans and the requirement to cover “essential health benefits” under provisions of the Affordable Care Act (ACA).

The proposed rule states that by expanding the definition of the term “employer” association based health plans will have new opportunities to negotiate terms with insurance companies that will benefit its members. AOPA’s primary concern with the proposed rule is that the proposed expansion of association health plans will significantly reduce the requirements for these plans to provide coverage for health benefits, including orthotics and prosthetics, which have been designated as essential health benefits by provisions of the ACA.

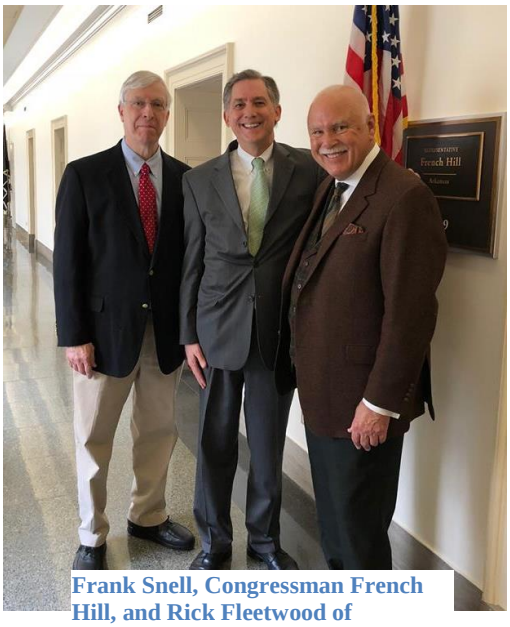
AOPA’ full comments may be reviewed by clicking here.

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

Wrap up of the 2018 AOPA Policy Forum

The 2018 AOPA Policy Forum held March 7-8 was another success that presented realistic opportunities for O&P to meet with Congressional representatives to improve patient care and advance other legislative objectives. With a recent legislative win under our belts, AOPA members and O&P users travelled to DC to visit lawmakers to build on this momentum, presenting their stories of the impact O&P makes on patients’ lives, and suggesting common sense solutions to issues obstructing O&P interventions.

Ninety-six O&P professionals and patients donned their advocacy hats during the March 8 visits to Capitol Hill, and visited with legislators in 500 appointments. Attendees encouraged lawmakers to support the Medicare O&P Improvement Act – the clinical notes provision was one part of the bill, but seven provisions remain that have not been enacted. Attendees also requested support for additional funding for O&P research and education, expressed the importance of Veterans' Choice, and took the opportunity to share other issues facing their patients and their businesses. The impact of the visits is not always immediate, but the cumulative effect of hearing from patients, clinicians, manufacturers, and AOPA and other O&P organizations is how we get lawmakers to share our concerns and promote our responsibility in the rehabilitative process.

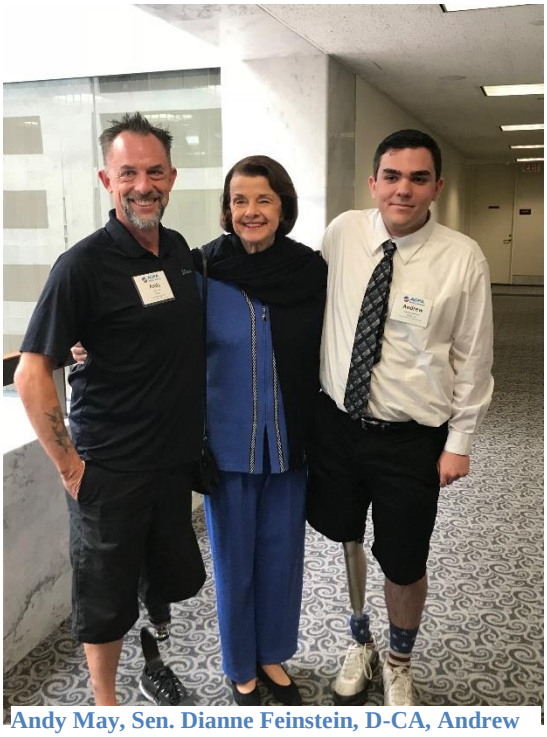


Frank Snell, Congressman French Hill, and Rick Fleetwood of

On the first day of the Policy Forum, attendees heard from Congressional members Rep. Peter Roskam (R-IL) and Rep. Mike Bishop (R-MI), who shared their insights on healthcare and their advice for advancing O&P's legislative agenda. Attendees then heard from a panel of experts including AOPA staff, lobbyists, board members and other voices in O&P to feel confident in their "asks" from lawmakers. On the second day attendees heard from Senator Ben Cardin and finalized their talking points and "asks", and headed to Capitol Hill.

AOPA staff will be following up with legislative staff to keep the ball moving forward. See more photos at [AOPA's Flickr site.]

From left: Justin Rheault, Nicole Ver Kuillen, Rep. DelBene (D-WA), Natalie Harold, David Boone



Andy May, Sen. Dianne Feinstein, D-CA, Andrew Seelhof

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AOPA 2018 policy forum

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Update on Clinicians' Notes Provision

So Congress (and the federal law) now says our orthotist/ prosthetist notes are officially part of the medical record for purposes of medical necessity determinations... now what?

What the new law says

The statute, as enacted, is comprised of one sentence which states:

*SEC. 50402. ORTHOTIST'S AND PROSTHETIST'S CLINICAL NOTES AS PART OF THE PATIENT'S MEDICAL RECORD. Section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) is amended by adding at the end the following new paragraph.
''(5) DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS.-For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1848(k)(3)(B).''.

Some Interim Suggestions for Submitting Claims

The sentence is unmistakably clear, to the point that it should be self-actuating, becoming actively in force as of the time of enactment. Since there were no regulations changed when the DME MACs changed policy by introducing the August 2011 "Dear Physician" letter, there does not seem any need for regulations to revert back to the previous policy. That being said, CMS often sees things through their own lens, so there is no assurance they won't issue a regulation of some kind regarding this issue.

That said, it seems CMS believes it needs to advise its contractors, in this case, the DME MACs, whenever there is a policy change. But before we get to that, here are some general suggestions-not based precisely in the law (which is only one sentence), but some common sense considerations as you submit claims in the interim until the major questions are resolved by some CMS announcement.

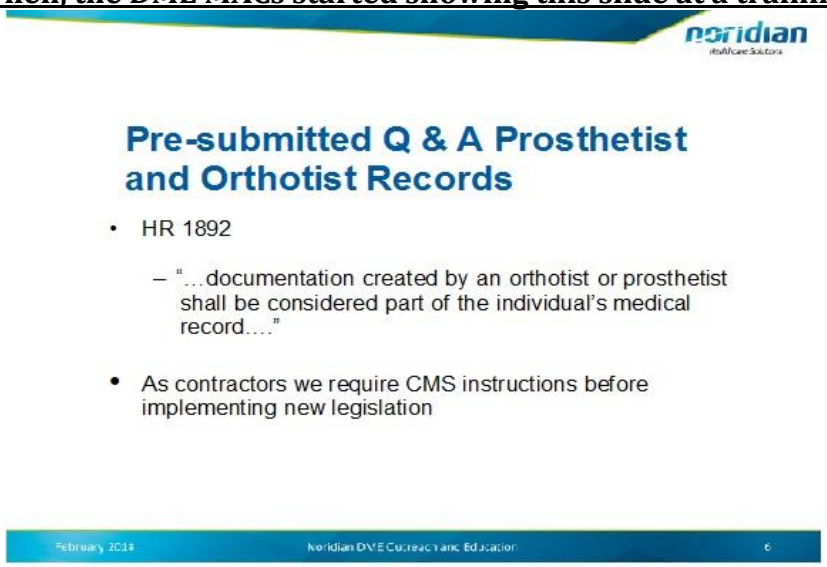
You should consider submitting a copy of the provision with every claim where you include copies of your notes. There is no clarity on timing from Congress. The new law clearly applies to prostheses and orthoses you fit and bill going forward. While the law is mute on intent to retrospective application, we believe it applies to all pending and new claims and appeals. CMS may, or may not announce their comparable view. There is nothing in the provision that says that, so it may take some battles with DME MACs to resolve the retrospective question, but we do have the high ground with a brand new provision.

Legally, the provision puts things back to where they were before the August 2011 "Dear Physician" letter. Then, the O/P practitioner notes could corroborate and provide additional details consistent with the physician records. The O&P notes cannot alone be the basis for satisfying the Medicare requirements of the prescription-they never could before and can't now. So, if the physician notes state that an orthotic patient's symptoms indicate likelihood of knee instability, and the O/P notes say our examination confirmed knee instability, that is probably fine. But if the physician makes no mention of knee instability, legally, the orthotist/prosthetist notes, standing alone, can't fill in that void.

The bottom line is while the jury is still out on how this law will ultimately be implemented, there is absolutely no harm in operating under the assumption that the law applies to outstanding

appeals. Anything that will increase the chances of acceptance of practitioner records as relevant to payment decisions is a good thing.

Then, the DME MACs started showing this slide at a training session:



While many were surprised and disillusioned by this slide, this is what government contractors do when faced with change. They don't want to take direct responsibility, and put their multi-million dollar contracts at risk. Rather, they say, "we're not making any changes, unless and until CMS tells us."

AOPA Outreach to CMS

AOPA is obviously interested in getting unresolved questions resolved, and for CMS to get out word to CMS contractors, and to get things moving as Congress intended.

On Friday, February 23, AOPA sent a letter from AOPA President Jim Weber and Executive Director Tom Fise to CMS Administrator Seema Verma requesting that the agency resolve the contractor's questions in order to get the law operational. (Read the letter.) We expect that this AOPA letter will not be the only one going to the CMS Administrator, because several Members of Congress who helped write and expect Section 50402 to be implemented smoothly and efficiently may also weigh in. We will continue to keep you informed as these actions unveil further.

AOPA Announces Requests for Proposals for Separate Research Grants

The American Orthotic & Prosthetic Association is proud to announce 5 Requests for Proposals for separate research grants.

As part of AOPA's Orthotics 2020 initiative, we are committed to making a major leap forward in clinical research that can answer some of the most important and profound issues about Orthotics. AOPA, together with its many partners among O&P manufacturers, patient care companies, and others entities committed to an evidence-driven future for O&P, will be funding one grant for each topic below in amounts of up to $60,000-$75,000, varying by topic - see each RFP for the specifics of the grant.

1. Orthotic Treatment for Stroke Patients
2. Back Bracing
3. Osteoarthritis of the Knee

4. Orthotic Treatment for Plagiocephaly in Pediatric Patients

In partnership with the Center for O&P Learning & Evidence-Based Practice (COPL), AOPA is accepting applications for pilot grants for up to $15,000-$30,000 for ten O&P topics, including an open topic (multiple grants will be funded).

- Pilot Grant RFP

The deadline for all proposals is April 30, 2018.

If you have any questions, please contact Yelena Mazur at ymazur@AOPAnet.org or 571/431-0876.

Low Volume Appeals (LVA) Initiative Has Begun

For those suppliers whose NPI numbers end in an even number (0, 2, 4, 6, 8) and have fewer than 500 appeals pending at Administrative Law Judge level or higher and each appeal has a total billed amount of $9,000 or less you may file an expression of interest for a limited settlement agreement. The agreement will result in a timely one-time partial payment of 62% of the net Medicare approved amount of the appeals in question.

If your NPI number ends in an even number and you wish to take part in the LVA your expression of interest must be filed by March 9, 2018. Suppliers with an NPI ending in an odd number (1, 3, 5, 7, and 9) your opportunity to take part in the LVA will begin March 12, 2018.

Just as a reminder - the new Medicare ID cards will be issued and mailed to beneficiaries starting in April 2018. Be sure you are prepared and ready for the new cards. To review what to expect with the new ID cards and what you can do to prepare please read the November 2017 issue of the O&P Almanac.

Questions? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

Attend the San Antonio Coding & Billing Seminar April 30-May 1

When: April 30 – May 1
Location: The San Antonio Marriott Riverwalk
889 E Market St
San Antonio, TX 78205

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

Book your hotel by April 6 for the $179/night rate by calling 800/648-4462 or online. Register by March 30 for early bird rate. Questions regarding the seminar may be directed to Joe McTernan at (571) 431-0811 or Devon Bernard at (571) 431-0854.

DME MACs Issue a Correct Coding Bulletin for Diabetic Shoe Inserts

On February 1, 2018 the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs) issued a correct coding bulletin that addresses proper coding of diabetic shoe inserts described by HCPCS codes A5512, A5513, and the recently created K0903 which describes custom fabricated, total contact inserts that are manufactured through a direct milling process that utilizes a digital model of the patient's foot to direct a CAM based system in the fabrication of the insert.

The correct coding bulletin indicates that the PDAC coding redetermination review project, which was initially announced in August of 2017 and scheduled to be completed by June 1, 2018 has been extended to a new completion date of August 1, 2018 to allow manufacturers and central fabricators additional time to submit applications for their respective products. All diabetic inserts billed to Medicare using A5513 or K0903 must be listed on the PDAC product classification list no later than August 1, 2013. Inserts that are not included on the PDAC list by August 1, 2018 must be coded as A9270 and will be considered non-covered by Medicare.

Direct milled inserts described by K0903 must be billed using K0903 for dates of service on or after April 1, 2018, the effective date of the code regardless of how they are currently listed on the PDAC product classification list. In addition, manufacturers and central fabricators of direct milled inserts must submit their product(s) to PDAC for review no later than April 1, 2018. While K0903 is effective for date of service on or after April 1, 2018, the Centers for Medicare and Medicaid Services (CMS) has not yet issued the Medicare fee schedule amount for K0903. As AOPA previously reported, the FAQ document that accompanied the announcement of the proposed changes to the DMEPOS quality standards that included direct milled, custom fabricated diabetic inserts in the definition of "molded to patient model" included a proposed 14% reduction in the Medicare fee schedule for direct milled inserts. AOPA has challenged this proposal based on several bases, including provisions within CMS' own instructions to contractors that require the direct crosswalk of established Medicare fee amounts when a single code is exploded into two or more similar codes, and final decision on the fee schedule amount is still pending within CMS leadership. AOPA believes that this instruction applies to the creation of K0903 as it is similar to existing code A5513. AOPA will continue to monitor CMS resources for information regarding the

Medicare fee schedule for K0903 and will communicate any new information to AOPA members as soon as possible.

The DME MAC correct coding bulletin may be viewed by clicking here.

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

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Upcoming AOPA Events

April 11, 2018	*Enhancing Cash Flow & Increasing Your Accounts Receivable* AOPA Webinar Learn more and register here
April 30 – May 1, 2018	Coding & Billing Seminar San Antonio, Texas Learn more and register here
May 9, 2018	*Coding: Understanding the Basics* AOPA Webinar Learn more and register here