AOPA In Advance SmartBrief
Breaking News
December 11, 2018

AOPA Headlines:

Updated Requirements for the RT and LT Modifiers

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) recently released a correct coding notification for the proper usage of the RT and LT modifiers; when billing for bi-lateral items/services on the same date of service.

Current rules for billing bilaterally direct you to use the RTLT modifier on the same claim line with two units of service. However, **for claims with dates of service on or after March 1, 2019** you must bill each item on two separate claim lines using the RT and LT modifiers, and one unit of service on each claim line. Bi-lateral claims with a date of service on or after March 1, 2019 billed with the RTLT on a single claim line, will be rejected as incorrect coding.

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

AOPA Supports the Alliance's Open Letter to the O&P Community

The Orthotic and Prosthetic Alliance has recently drafted and distributed an open letter to the O&P community regarding sexual misconduct, harassment, and discrimination in the workplace.

AOPA is proud to stand and support this zero tolerance policy for sexual misconduct, harassment, and discrimination based on sexual orientation, gender identity, race, color, religion, age, national origin, and disability, as well as any retaliation for the reporting of such conduct.

We would like to encourage you to engage your workforce in this conversation by the distribution of this letter. The letter can be viewed here.

AOPA appreciates your thoughts and input on this letter and the topic at hand. Please send your input to info@AOPAnet.org. We look forward to hearing from you.

Department of Veterans Affairs Releases Supplemental Proposed Rule on Veterans Choice of Provider

On November 28, 2018, the Department of Veterans Affairs (VA) released a Supplemental Notice of Proposed Rulemaking (SNPRM) regarding the provisions of the October 2017 proposed rule that addressed the Veterans right to choose their provider for provision of artificial limbs. The SNPRM was issued in response to the significant comments that the VA received on these provisions in the original, yet to be finalized proposed rule.

The heart of this issue is whether the VA has the right to determine whether a veteran must receive prosthetic care within the confines of the VA medical center system or whether they have the right to choose to work with contracted providers within the community. For many years, this has not been an issue as veterans, in most cases, were free to receive prosthetic care directly from the VA or from contracted providers. The October 2017 proposed rule clearly indicated that the VA, and solely the VA had the authority to determine where veterans received prosthetic services. In its comment on the proposed rule, AOPA strongly objected to the proposed change, as did other groups, including several veterans service organizations.

The SNPRM addresses the comments it received on this issue and "seeks to clarify the intent of the proposed regulation, explain the VA's current practices and processes relating to the provision, and request additional details on it."

AOPA's preliminary review of the SNPRM indicates that the VA still contends that it reserves the right to full discretion regarding how a veteran receives prosthetic services including whether the veteran can seek care from community-based prosthetists. While the SNPRM discusses the involvement and importance of community-based care in certain circumstances, AOPA believes that the VA remains overly restrictive in the SNPRM and its authority to determine where a veteran receives prosthetic services.

Comments on the SNPRM are due on December 28, 2018. AOPA will complete its review of the SNPRM and will be filing comments accordingly. The complete SNPRM 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.

NAAOP Announces 2019 Fellowship on Public Policy and Advocacy

ATTENTION ALL O&P CONSUMERS: The National Association for the Advancement of Orthotics and Prosthetics (NAAOP) is soliciting applications for its annual health policy/advocacy fellowship. NAAOP is a national nonprofit association advocating for consumers/patients requiring orthotic and prosthetic care, as well as the providers who serve them. The NAAOP Fellowship is a paid, 10-week summer program based in Washington, D.C. The fellow will learn about orthotic and prosthetic (O&P) policy, advocacy, and how NAAOP and other O&P organizations function on behalf of the O&P community and within the broader rehabilitation and disability policy and advocacy environment at the federal and state level. The fellowship also includes exposure to O&P clinical and business settings, and state-based public policy and advocacy, at no cost to the fellow.

Two fellows will be selected for the summer of 2019 through a competitive process using the application on the www.naaop.org website. The deadline to electronically submit this application is January 31, 2019 by 12:00 Midnight, Eastern Time. Finalists will be interviewed via videoconference and two will be selected, assuming high quality candidates are identified. If the finalists selected cannot accept the fellowship for any reason, the next highest ranked fellow will be offered the position.

Application Deadline: 12:00 Midnight, Eastern Time, Thursday, January 31, 2019

- Applications must be submitted electronically to Fellowship@naaop.org.

Fellowship Selection Announcement: March 6, 2019
Fellowship Term: 10-weeks (May 27th to August 2, 2019).

Download 2019 NAAOP Fellowship Application

Enjoy this Special Offer through AOPAversity

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Please use the promo code "twenty" to access the discounted savings!
This promotion will last through January 31, 2019.

PDAC Contract to Transition to Palmetto GBA Effective January 15, 2019

The Centers for Medicare and Medicaid Services (CMS) has awarded the Pricing, Data Analysis, and Coding (PDAC) contract to Palmetto GBA with a transition date of January 15, 2019. Palmetto GBA will replace Noridian Healthcare Solutions who has held the PDAC contract since August 2008.

Palmetto GBA currently holds the contracts to serve as the National Supplier Clearinghouse and the Competitive Bidding Implementation Contractor. In addition, Palmetto GBA served as the contractor for the SADMERC, which was renamed the PDAC when the contract was awarded to Noridian in 2008.

Doran Edwards, MD will serve as the PDAC medical director under the new contract. Dr. Edwards is currently an associate medical director for CGS which serves as the Jurisdiction B and Jurisdiction C DME MAC.

The announcement regarding the transition of PDAC duties from Noridian to Palmetto GBA may be viewed on the Palmetto GBA website by clicking here.

There has been no announcement to date regarding new procedures to submit code verification requests, but it is expected that an announcement will be made prior to the January 15, 2019 transition date.

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

Act Now: Submit Comments on OTS Competitive Bidding

The Centers for Medicare and Medicaid Services (CMS) is soliciting comments on its proposed inclusion of off-the-shelf (OTS) spinal orthoses and OTS knee orthoses as product categories in the next round of Medicare competitive bidding. While the impact of inclusion of OTS spinal and knee orthoses will not be felt for at least two years, there is a current delay in the implementation of future rounds of competitive bidding until at least January 2021, the recent CMS announcement represents the first indication that OTS orthoses of any kind will be included in competitive bidding.

There are 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 a 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; especially considering the inappropriate expansion of the definition of OTS.

AOPA 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. Click here to submit pre-drafted comments to CMS via email. *Comments must be submitted by midnight on December 17, 2018.*

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.

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.

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