American Orthotic & Prosthetic Association

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AOPA In Advance SmartBrief
Breaking News
November 14, 2019

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HCPCS Code Changes for 2020

The Centers for Medicare and Medicaid Services (CMS) has released the new Healthcare Common Procedure Coding System (HCPCS) codes for 2020, 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, 2020.

New Codes

HCPCS	Descriptor
L2006	Knee ankle foot device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each

Change to Code Descriptor

HCPCS	New Descriptor	Previous Descriptor
L8032	Nipple prosthesis, **prefabricated,** reusable, any type, each	Nipple prosthesis, reusable, any type, each

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 11, 2020 AOPAversity webinar (New Codes for 2020, Other Updates & Yearly Round-up) which will focus on the changes to the HCPCS code set and any other upcoming Medicare changes which may impact your business in 2020.

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

HHS Office of Inspector General Releases a Report Comparing Medicare Payment for Orthoses with Payments by Other Insurers

On October 30, 2019, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a report that compared Medicare payments for orthoses to payments made by non-Medicare payers from 2012-2015. The OIG cited an increase in Medicare payments for certain spinal, knee, elbow, and wrist orthoses from $631.8 million in 2012 to $815.5 million in 2015 as the reason for conducting its investigation. The OIG reported that for 142 orthosis codes, Medicare paid $337.5 million more than non-Medicare payers during the three-year review period. The OIG reported that for 19 orthotic codes, Medicare actually paid $4.7 million more than non-Medicare payers during the same three-year period.

AOPA was aware that the OIG was considering reviewing Medicare payments for orthoses compared with non-Medicare payments, as the issue has been included in the OIG's annual workplan since 2016. Upon first mention in the 2016 workplan, AOPA notified members of the potential report and commissioned a legal memo from McGuire Woods, LLP that discussed the potential risks associated with charging Medicare more than a provider's usual and customary charges. The 2016 communication to AOPA members and McGuire Woods memo can be viewed here.

In its recent report, the OIG recommended that, where applicable, the Centers for Medicare and Medicaid Services (CMS) consider using its inherent reasonableness or other authority to reduce (or to a much lesser extent, increase) the Medicare fee schedule for the 161 codes identified in the OIG report. The OIG pointed out that existing CMS regulatory authority could be used to adjust fee schedules for 95 of the 161 codes. The other 66 codes would require statutory changes to properly adjust the fees. In its response to the OIG report, CMS stated that certain off-the-shelf (OTS) spinal and knee codes have already been included in the competitive bidding program scheduled for implementation in 2021 and fees should be adequately reduced as a result of provider competition. CMS also indicated that it would consider including additional OTS orthoses in future rounds of DMEPOS competitive bidding. CMS also indicated that it has recently issued a final rule regarding calculating Medicare fee schedules for new HCPCS codes that may be useful in determining appropriate fees for new orthotic codes.

The potential impact of the OIG report will most likely take several years for CMS to implement through regulatory and legislative channels. AOPA understands the significant ramifications that this report may have on its members, the O&P industry in general, and especially Medicare beneficiaries who may be forced to receive substandard orthotic care from unqualified, non-certified, or non-licensed practitioners as a result of arbitrary and unreasonable reimbursement reductions.

Over the next several weeks, AOPA will be performing a comprehensive analysis of the potential impact, including individual analysis of each HCPCS code discussed in the report, the current and historic O&P provider market share of each code, and the potential impact a reimbursement reduction may have on each code. Based on this analysis, AOPA will aggressively pursue all strategies that will reduce the impact of the OIG report and ensure that AOPA members can continue to provide high quality orthotic care to Medicare beneficiaries and receive equitable Medicare reimbursement. AOPA will continue to provide on this issue.

The complete OIG report can be found here.

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

CMS Issues Final Rule on 2020 Medicare Payment Rules for DMEPOS

On October 31, 2019, the Centers for Medicare and Medicaid Services (CMS) released its annual final rule regarding changes to the 2020 Medicare payment rules for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). CMS issued a proposed rule in late July of this year and allowed any interested member of the public to provide written comments on the proposed rule until September 27, 2019.

AOPA reviewed the proposed rule and submitted comments on several proposed changes to Medicare DMEPOS payment policy for 2020. AOPA's concerns focused on proposed changes to the gap filling methodology that Medicare is statutorily required to use to establish Medicare fee schedules for new HCPCS codes, the proposed combination and expansion of the CMS "master list" of HCPCS codes subject to prior authorization, face to face visit requirements, and written orders prior to delivery (WOPD), and the authority of CMS to reduce Medicare fee schedules for products that have had price reductions through market competition within five years of creation of a new HCPCS code.

While CMS acknowledged all of the comments it received in response to the proposed rule, the only section of the proposed rule that it elected not to finalize was a provision that would use technology assessments, which would compare new DMEPOS technology to existing DMEPOS technology in order to help CMS establish Medicare fee schedules for new HCPCS codes. CMS decided to consider this provision of the proposed rule in the future. All other provisions of the proposed rule related to DMEPOS were finalized in the final rule despite significant concerns from the public expressed in response to the proposed rule.

AOPA is disappointed in CMS' lack of response to the comments it received regarding the proposed rule. In most instances, CMS simply stated that they disagreed with the submitted comments with minimal explanation as to why and indicated that it would finalize the proposed provision as written.

AOPA understands the importance of establishing and maintaining a positive relationship with CMS and its value in achieving AOPA's m
ission of improving patient access to quality orthotic and prosthetic care through advocacy, research, and education. AOPA continues to strive toward creating effective, two-way communication with CMS, its contractors, and its leadership. Past successes include efforts to prevent the creation of an unreasonable, non-patient focused local coverage determination for lower limb prostheses, AOPA representation on the DME MAC Advisory Councils and successful challenges to inappropriate RAC audit activity. AOPA will continue to press CMS for better transparency and greater stakeholder input in its policy making process and continue efforts to be the voice of the O&P profession on policy issues.

The complete final rule may be viewed here.

Jurisdiction D Releases Quarterly TPE Results

Noridian, the Durable Medical Equipment Administrative Contractor (DME MAC) for Jurisdiction D, recently published the quarterly results of their Target, Probe & Educate (TPE) audits. The audits are based on claims reviewed during April 2019-June 2019 and the results are as follows:

- Ankle Foot Orthoses/Knee Ankle Foot Orthoses (L4360, L4361, L4386 and L4387) had an overall claim potential improper payment rate, based on dollars, of 51%. This is an increase in overall claim potential improper payment rate from the last quarter's results of 31%.
- Knee Orthoses (L1810, L1812, L1830, L1832, L1833, L1843, L1845 and L1852) had an overall claim potential improper payment rate, based on dollars, of 61%. This is decrease in overall claim potential improper payment rate from the last quarter's results of 61%.
- Spinal Orthoses (L0625, L0626, L0627, L0630, L0631, L0637, L0641, L0642, L0643, L0648 and L0650) had an overall claim potential improper payment rate, based on dollars, of 60%. This is the same as last quarter's results.
- Diabetic Shoes (A5500) had an overall claim potential improper payment rate, based on dollars, of 49%. This is an increase in overall claim potential improper payment rate from the last quarter's results.

The top and common denial reasons for all TPE results (in no order) are as follows:

- Documentation does not support basic coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter
- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.

View the complete results and a full list of denial reasons here.
Questions? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

AOPA Participates in MedPAC Public Meeting

On September 5, 2019 AOPA staff attended the monthly public meeting of the MedPAC Commission which is charged with advising the Congress on issues regarding Medicare policy. AOPA was represented by Justin Beland, Director of Government Affairs and Joe McTernan, Director of Coding and Reimbursement, Education, and Programming. A topic of discussion on the MedPAC agenda was a review of the Medicare DMEPOS Competitive Bidding Program, specifically the national competitive bidding program for mail order diabetic test strips. While the session began with a focus on diabetic test strips, the commissioners quickly began discussing the DMEPOS Competitive Bidding program in general, including its relative success in achieving significant savings for the Medicare program without significant patient issues. MedPAC staff presented data that supported the premise that competitive bidding did not result in significant patient access issues. The commissioners discussed the potential expansion of DMEPOS competitive bidding and discussed how competitive bidding could potentially be expanded beyond DMEPOS into other areas of the Medicare program.

AOPA offered verbal comments during the public comment section of the session and cautioned the commission on the concept of expanding competitive bidding into non-commodity services such as custom fitted and custom fabricated orthoses and prostheses. AOPA stressed the importance of ensuring that Medicare beneficiaries continue to have access to high quality clinical care provided by properly certified and/or licensed practitioners. AOPA also asked the commission to continue to support an exemption from competitive bidding for orthotists and prosthetists as mentioned in its June 2018 report to congress.

Reconsideration Request Contact Information Update

As previously reported the new Qualified Independent Contractor (QIC) contractor is Maximus Federal Services, Inc and they will be replacing C2C Innovative Solutions. As of September 1, 2019, all Reconsideration requests, level two appeals, should be submitted to Maximus Federal Services, Inc. Requests can be submitted in writing to the following address:

Maximus Federal Services, Inc.,
Medicare DME,
3750 Monroe Avenue, Suite 777,
Pittsford, NY 14534-1302

Reconsideration requests may also be submitted via the QIC Appeals Portal at https://qicappeals.cms.gov.

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

Revised Medical Necessity Criteria for MPK's

BCBS Illinois, BCBS Montana, BCBS New Mexico, BCBS Oklahoma, BCBS Texas, HCSC: Lower Limb Prosthetics, Including Microprocessor-Controlled Prosthetics - Med Policy

Released revised draft policy with the following proposed changes to criteria and supporting information.

Revised medical necessity criteria for microprocessor-controlled and powered knee (MPK); replaced K-PAVET score requirement with Medicare's classification of functional level (MFL) K2, K3, or K4; revised criterion regarding physical ability to add strength and balance as examples.

Removed experimental, investigational, and/or unproven policy statement for the Genium Bionic Prosthetic System microprocessor-controlled knee.

Revised not medically necessary policy statement for MPK to replace K-PAVET scores with MFL 0.

Revised medically necessary policy statement for a four-axis, hydraulic or pneumatic hip joint (e.g., Helix 3D Hip [OttoBock]) to replace K-PAVET score requirement with MFL K3 or higher, and change use in conjunction with the OttoBock C-leg from a requirement to an option.

Added table of Medicare's classification of functional levels to the coverage section.

Removed all scoring information for the K-PAVET guide from the coverage section.

Updated notes in the coverage section. Updated description, rationale, and references sections.

Draft posted: 08/01/2019.
Comment period ends: 08/16/2019.

View Full Policy - Payer Website

CMS Releases Proposed Rules for ESRD PPS & Gap-Filling Methodologies

The Centers for Medicare and Medicaid Services (CMS) recently released a proposed rule to update the End Stage Renal Disease (ESRD) Prospective Payment System (PPS), and included in the proposed rule were major changes to the gap-filling methodology. Gap-filling is the current procedure for how new introduced products and HCPCS codes receive a fee schedule amount.

AOPA staff is currently reviewing the proposed rule in more detail.

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

Medicare DME QIC Contract to Transition from C2C to Maximus

The contract to serve as the Medicare Qualified Independent Contractor (QIC), which processes Medicare reconsideration requests, will transition from C2C Innovative Solutions, Inc. to Maximus Federal by the end of 2019. C2C will hold its last re-opening discussion on September 15th and all

pending reconsideration requests will be completed by December 31, 2019. Information regarding when MAXIMUS will begin accepting Medicare reconsideration requests has not yet been released.

C2C spearheaded a popular telephone re-opening process during its tenure as the QIC which drastically reduced the number of reconsideration denials. It is not yet known whether MAXIMUS will continue this process as part of its QIC contract.

AOPA will continue to follow this story and provide updates on the transition as they are available.

Don’t Sleep on the Latest AOPA Member Resource

Are you utilizing your AOPA membership? Attend the upcoming live tutorial to learn about one of the best resources available for O&P practices, the AOPA Co-OP.

A Wikipedia for all things O&P, the Co-OP is a one-stop resource for information about reimbursement, coding, and policy. It is searchable database that provides up-to-date information on developments in Medicare policy, state-specific legislation, private-payer updates, and more. Members can access detailed information on everything from modifiers to product-specific L Codes and associated policies. Additionally, members can share information and insights on developments impacting the entire O&P profession.

If you haven't signed up for the Co-OP yet, this is your opportunity to learn about O&P's most comprehensive resource for coding, billing, and reimbursement. AOPA’s Director of Strategic Initiatives, Ashlie White will demonstrate how to use the Co-OP and answer all your questions.

Register now for FREE:

- Friday, December 6 at noon ET

Upcoming Events

December 11, 2019	*New Codes for 2020, Other Updates and Yearly Round-Up* AOPA Webinar Learn more and register
January 8, 2020	*Modifiers: Enhance Your Claims Two Letters at a Time* AOPA Webinar Learn more and register
February 12, 2020	*O&P Coding & Billing Myths: The Truth is Out There* AOPA Webinar Learn more and register