AOPA In Advance SmartBrief
Breaking News
September 29, 2020

AOPA Headlines:

Virtual Coding & Billing Seminar

Wondering what is going on in regard to O&P coding, billing, and reimbursement policy?

Then, join our experts November 9 and 10 for the AOPA Virtual Coding and Billing Seminar.
It is what you've come to expect from our Coding and Billing seminars but tweaked and condensed slightly to offer it virtually. Content will be presented from 12-4pm ET both days.

The cost before October 20 is $295 for members and $395 for nonmembers. After that the cost increases to $320 for members and $420 for nonmembers. Bonus, if you register by October 20 you will receive a FREE 2020 Quick Coder.

Attendees will earn 8 CE credits.

Get the latest on coding, billing, and reimbursement policy, register for the Virtual Coding and Billing Seminar today. Have specific coding or billing questions, submit them when you register!

Questions? Contact Devon Bernard at dbernard@AOPAnet.org.

COVID-19 Update: Provider Relief Fund Reporting

On September 19, 2020, the US Department of Health and Human Services (HHS) released guidance articulating how to account for lost revenues and expenses and addressing recipient reporting requirements for those receiving Provider Relief Fund (PRF) payments. The guidance applies generally to PRF recipients that received one or more PRF payments exceeding $10,000.

The $10,000 reporting threshold is a notable change from the statutory requirement in Section 15011 of the CARES ACT; which (and the Provider Relief Fund Terms and Conditions) had required recipients of more than $150,000 in total funds appropriated under the CARES Act to submit a report to HHS within 10 days following the end of each calendar quarter. While the new guidance lowers the reporting threshold to $10,000, it does not clarify if HHS's public reporting will continue to satisfy the Section 15011 requirement and did not further specify how (or whether) the reporting information announced in the guidance relates to the Section 15011 requirement. We expect further guidance on the issue, and will report when additional guidance is released. Recipients should continue to monitor the PRF FAQs for additional clarifications on reporting requirements.

The new guidance stipulates that recipients will report on the use of their PRF payments by first submitting information on healthcare-related expenses that are directly attributable to coronavirus. This may include general and administrative expenses and/or healthcare-related operating expenses. Any PRF payment amounts that were not fully expended on healthcare-related expenses attributable to coronavirus are then applied to the provider's "lost revenues," which, under the new guidance, are now defined as "year-over-year net patient care operating income (i.e., patient care revenue less patient care related expenses)." This definition is more limited than previous HHS guidance which permitted "any reasonable method of estimating lost revenue;" providers could compare budgeted to actual or use a year-over-year comparison. In addition, HHS appears to cap the application PRF payments toward lost revenues up to either the amount of a provider's 2019 net gain from healthcare related sources or up to a net zero gain/loss

in 2020, if the provider reported negative net operating income in 2019. HHS seems to have provided this clarification because, under previous guidance, if lost revenues could be applied to expenses irrespective of the impact on margin, it would have introduced the possibility of PRF funding making a healthcare provider more profitable in 2020 than it was in 2019. AOPA is concerned about the potential impact of this approach for some providers and will continue to monitor the issue.

Recipients that do not use the full amount of their PRF funds by the end of calendar year 2020 will have an additional six months to use the remaining amounts. The extra six-month reporting period (January-June 2021) will be compared to the same period in 2019 for the purposes of making calculations.

The new guidance stipulates that recipients will be required to report several data elements, including demographic information, information about their expenses attributable to coronavirus, information about their lost revenues, and other non-financial information (such as metrics on personnel, patients, and facilities). Recipients that received between $10,000 and $499,999 in aggregated PRF payments must report healthcare-related expenses attributable to coronavirus in two aggregated categories: (1) general and administrative expenses and (2) other healthcare-related expenses. Providers receiving $500,000 or more in PRF payments will report their expenses in greater detail within each of these categories.
The guidance has also pushed the reporting window, the reporting portal will be available in early 2021 (instead of on October 1, 2020). The other deadlines appear to remain unchanged, but these deadlines may be adjusted as the reporting mechanism is gradually rolled out. Important reporting deadlines include:

- All recipients must report within 45 days of the end of the calendar year 2020. (This would fall on Sunday, February 14; the actual deadline will likely be clarified as Monday, February 15.)
- Recipients who have expended funds in full prior to December 31, 2020, may submit a single final report at any time during the first reporting window (early 2021 through February 15, 2021).
- Recipients with funds still unexpended after December 31, 2020, must submit a second and final report no later than July 31, 2021.

Finally, the new guidance does not change HHS' previous clarifications that payments from the PRF qualify as disaster relief payments and are therefore taxable income. AOPA continues to work with Congress on bipartisan legislation which would ensure that CARES Act PRF payments are not includible in gross income.

AOPA will continue to follow this and all CARES Act-related guidance. If you have any questions, please contact Justin Beland, Director of Government Affairs.

AFO/KAFO Policy Article

Recently, AOPA asked the DME MACs to clarify this existing language in the AFO/KAFO Policy Article related to custom fabricated braces: *In addition, if the item is custom fabricated, a complete and clear description of the item, including what makes this item unique, and a breakdown of charges (material and labor used in fabrication). This information should be entered in the narrative field of an electronic claim.*

On September 3, AOPA reported and confirmed that there has been no change to the documentation requirements for custom fabricated AFOs/KAFOs and the above passage is in reference to miscellaneous or unlisted codes. The DME MACs also stated they will clarify this in a future Policy Article revision.

The DME MACs just released the following revised AFO/KAFO Policy Article, and as promised they clarified the custom fabrication language: *If the item is custom fabricated and does not have a specific HCPCS code, a complete and clear description of the item, including what makes this item unique, and a breakdown of charges (material and labor used in fabrication) should be entered in the narrative field of an electronic claim or on Item 19 of a paper claim. (Refer to the LCD-related Standard Documentation Requirements article (A55426) for more information regarding billing of items with HCPCS codes that include miscellaneous, NOC, unlisted, or non-specified in their narrative descriptions.)*

The revised AFO/KAFO Policy Article will be effective October 1, 2020. A copy of the revised article can be found here.

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

2020 Virtual National Assembly, Content to Remain Available Through 2020

Thank you for attending the 2020 Virtual National Assembly, your participation helped make it a success!

Please take a minute to complete the Attendee Evaluation so that we can continue to improve your Assembly experience.

A huge bonus to this year's Assembly is you still have access to all the content, both the education and the exhibits. And, we are excited to announce that the platform will remain open for the remainder of 2020 (not just through October 12). To access it, login like you did during the Assembly. Once in you can watch any presentations you missed or review a session you attended. If a presenter made their slides available, you can download these as well. The exhibit booths, including exhibitors' contact information are still accessible too, so stop by and check them out.

This means you now have until the end of 2020 to earn over 100 CE credits. AOPA will send CE credit information to ABC and BOC mid-October, mid-November, and at the end of the year.

Thank you again for your participation! Be sure to save the date for the 2021 National Assembly, September 9-12, 2021 in Boston.

Questions about any of this? Contact us at Assembly@AOPAnet.org or (571) 431-0876.

Thank You to AOPA's National Assembly Sponsors!

CGS Announces Reviews for L1833 and L1851 - Update

CGS and Noridian have announced that they will be conducting widespread post-payment reviews for two knee orthoses:

L1833- Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf

L1851- Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf

These two braces were selected for post payment review based on internal data analysis and CERT audit results.

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

DME MACs Clarify AFO/KAFO Policy Article Language Regarding Custom Fabricated Orthoses

The DME MACs have recently clarified language in the AFO/KAFO Policy Article that currently states the following:

MISCELLANEOUS

In addition, if the item is custom fabricated, a complete and clear description of the item, including what makes this item unique, and a breakdown of charges (material and labor used in fabrication). This information should be entered in the narrative field of an electronic claim.

Previous versions of the Policy Article contained the same language but also included contextual language that clearly indicated that the additional requirements only applied to services described by unlisted procedure codes for lower limb orthoses (L2999).

AOPA asked the DME MACs to clarify that the current language is **NOT** intended to apply to all custom fabricated AFO/KAFO codes and that the contextual reference to unlisted codes that was present in previous versions of the Policy Article was an inadvertent omission.

The DME MACs have confirmed that there has been no change to the documentation requirements for custom fabricated AFOs/KAFOs and that the additional information referenced in the Policy Article is only required when submitting unlisted codes. They indicated that they will clarify this further in a future revision to the AFO/KAFO Policy Article.

CGS Post Payment Review for L0650 Announcement

In July, we informed you that the Centers for Medicare and Medicaid Services (CMS) announced the resumption of certain audit activity beginning on August 3, 2020. CMS clarified that they will not be restarting all audits on August 3, but instead due to the continued Public Health Emergency (PHE) will be implementing a phased approach to allow suppliers time to prepare and adjust.

The audits will begin with limited Durable Medical Equipment Medicare Administrative Contractor (DME MAC) based post-payment reviews and will only involve claims with dates of service prior to the beginning of the declared PHE on March 1, 2020.

CGS, the DME MAC for Jurisdictions B & C, has just announced that they will be conducting a complex post-payment review for L0650, an off-the-shelf LSO. The review will be for claims with dates of service prior to March 1, 2020. If you receive additional documentation requests as part of this review be sure to respond to them, however be advised that CMS has implied that the DME MACs may allow for flexibility with extensions and the cancelling of audits based on individual supplier's ability to complete the audit.

As of now, there is not a timeframe for when the Target, Probe, and Educate (TPE) program, and other audits will resume. AOPA will continue to monitor the resumption of CMS audit activity and provide you with timely updates.

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

Take Action: Support O&P and its Patients

On August 6, the Senate introduced the Medicare O&P Patient-Centered Care Act (S. 4503). This bipartisan legislation would improve access to, and quality of, orthotic and prosthetic care while simultaneously combatting fraud and abuse. The Senate bill is identical to the one introduced in the House late last year (H.R. 5262). The American Orthotic and Prosthetic Association (AOPA) thanks YOU for all your efforts to get this vital legislation introduced in both the House and Senate!

To move this legislation forward, we need to garner as much support as possible for it. **Please take a few minutes to write to your Representative and Senators and urge them to support this important legislation - simply enter your information in on the platform, personalize the letter as you see fit - it's important to tell YOUR story - and click send.**

These bills would:

- Distinguish the clinical, service-oriented nature in which O&P is provided from the commodity-based nature of the durable medical equipment (DME) benefit. Orthotics and prosthetics care includes a patient care component that is decidedly more in-depth and personal than simply supplying DME. Most orthotic and prosthetic devices are custom fabricated or custom fit and require the expertise of an orthotist or prosthetist who receive Master of Science degrees and residence training before becoming certified practitioners. Distinguishing O&P from DME would also create a path to billing for telehealth, which is increasingly important during the COVID pandemic.
- Restore congressional intent by revising the overly expansive regulatory interpretation of the meaning of "off-the-shelf" (OTS) orthotics to clarify that competitive bidding may only apply to orthoses that require minimal self-adjustment by patients themselves, not the patient's caregiver or a supplier. Congress created a definition of OTS orthotics as devices "requiring minimal self-adjustment for appropriate use" that "do not require expertise in trimming, bending, molding assembling, or customizing to fit to the individual." However, the Centers for Medicare and Medicaid Services (CMS) has changed and expanded the definition beyond Congress' intent. CMS defines minimal self-adjustment as an adjustment the "beneficiary, caretaker for the beneficiary or supplier can perform" - which is clearly not "self-adjusted." This expansion of Congress' definition places beneficiaries at risk for harm if they receive orthotic devices without the services that are necessary to ensure that these devices provide proper bracing.
- Reduce the likelihood of waste, fraud, and abuse in the Medicare program by prohibiting the practice of "drop shipping" (shipping an orthoses or prostheses to a beneficiary without first receiving direct patient care from a trained, certified or licensed health care practitioner) of orthotic braces that are not truly "off-the-shelf" (i.e., subject to minimal self-adjustment by the patient him- or herself).

All it takes is a few minutes, please take the time and write your legislators TODAY and urge them to support these important bills. Educating Congress on the issues surrounding the O&P profession is vital to businesses and more importantly patients - if we don't advocate for our needs and the needs of patients, no one will.

If you have any questions, contact Justin Beland, AOPA Director of Government Affairs, at jbeland@aopanet.org.

Prior Authorization Requests for Michigan, Pennsylvania, Texas and California

The DME MACs will begin to accept prior authorization requests (PAR) for codes L5856, L5857, L5858, L5973, L5980 and L5987 for all beneficiaries in California, Michigan, Pennsylvania, and Texas on August 18, 2020 for items delivered on or after September 1, 2020. This early submission date is to allow for the 10-day processing time for all PARs.

Here is quick recap of the prior authorization process:

- Complete your DME MAC's prior authorization request (PAR) coversheet for LLP

- Submit the coversheet and all supporting documentation (the SWO and any additional records to support medical necessity) for review. Submissions may be done by fax, mail, or DME MAC web portals.
- Receive either an affirmative or non-affirmative decision and a unique tracking number (UTN).
- If you received a non-affirmative PAR, you may attempt to fix any errors and resubmit your PAR.

If you received an affirmative PAR, you may submit your complete claim for payment and be sure to include your UTN on the claim.

CMS Delays Mandatory Use of Revised ABN Form

The Center for Medicare and Medicaid Services (CMS) has announced that mandatory use of the revised ABN (CMS-R-131 exp. 6/30/2023) form will now be January 1, 2021.

In late June CMS released the new and revised CMS-R-131, the ABN form with an expiration date of 6/30/2023, for immediate use. Mandatory use of the new form was to begin on August 31, 2020, but now will be January 1, 2021.

Suppliers can continue using the ABN form with the expiration date of 03/2020, or they may use the revised form.

The new ABN form with instructions may be found here.

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

Update on CMS Resumption of Medicare Audits

On July 10, we informed you that the Centers for Medicare and Medicaid Services (CMS) announced the resumption of certain audit activity beginning on August 3, 2020.

AOPA, through its involvement on the DME MAC Advisory Councils has since learned that CMS has clarified the scope of the audits that will resume on August 3. CMS will not be restarting all audits on August 3, but instead due to the continued Public Health Emergency (PHE) will be implementing a phased approach to allow suppliers time to prepare and adjust. The audits will begin with limited DME MAC based post-payment reviews and will only involve claims with dates of service prior to the beginning of the declared PHE on March 1, 2020.

As of now CMS did not provide a timeframe for the next phase or for the renewal of audit activity through the Target, Probe, and Educate (TPE) program, RAC audits or SMRC audits. CMS also reiterated that the DME MACs may allow for flexibility with extensions and the cancelling of audits based on individual supplier's ability to complete the audit.

AOPA will continue to monitor the resumption of CMS audit activity and provide you with timely updates.

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

Correct Coding Reminder for Scoliosis Braces

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Pricing, Data Analysis and Coding (PDAC) contractor just released a correct coding reminder for five base codes used to describe scoliosis braces: L1000, L1005, L1200, L1300 and L1310.

The L1005 (tension-based scoliosis and accessory pads), L1300 (other scoliosis procedure, body jacket molded to patient model) and L1310 (other scoliosis procedure, post-operative body jacket) are considered to be complete devices and all inclusive. The use of any other addition codes will be considered unbundling and incorrect coding.

The L1000 (CTLSO, Milwaukee, inclusive of furnishing initial orthosis) is a custom fabricated scoliosis brace and the following addition codes may be incorporated into the brace and are eligible for separate payment: L1010, L1020, L1025, L1030, L1040, L1050, L1060, L1070, L1080, L1085, L1090, L1100, L1110, and L1120. The listed addition codes will also be denied as not separately payable if billed with a base code other than the L1000.

The L1200 (TLSO, inclusive of furnishing initial orthosis only) may have the following addition codes incorporated into the brace and are eligible for separate payment: L1210, L1220, L1230, L1240, L1250, L1260, L1270, L1280, and L1290. The listed addition codes will also be denied as not separately payable if billed with a base code other than the L1200.

A copy of the full correct coding reminder may be found here.

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

Facility Site Visits and Accreditation Requirements Re-Instated

The Centers for Medicare and Medicaid Services (CMS) recently updated their COVID-19 Medicare Provider Enrollment Relief frequently asked questions document. In the document they stated that CMS will resume all accreditation and reaccreditation activities, and provider enrollment site visits as of July 06, 2020. These activities were previously suspended as part of the response to the declared public health emergency (PHE) for COVID-19.

If you initially enrolled after March 3, 2020 without obtaining the appropriate accreditation you must now submit a completed application to your Accrediting Organization (AO) within 30 days of notification from the National Supplier Clearinghouse (NSC). If you have received an extension for an expiring supplier accreditation due to the PHE you will be contacted by the NSC to begin the reaccreditation process. Certain accreditation and reaccreditation activities may be conducted onsite and in-person, virtually or a combination of both depending on your state's reopening plan. All onsite survey activities will be conducted in accordance with the Center for Disease Control (CDC) and local guidelines

If CMS, the NSC or one of their agents conducts an in-person provider enrollment site visit the inspector will follow all state and local requirements regarding the use of appropriate personal protective equipment (PPE) when conducting the site visit.

CMS is still temporarily ceasing all revalidation efforts for Medicare providers or suppliers until further notice.

You may access the complete updated FAQ document here.

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

CMS Announces the Resumption of Medicare Audits and New Implementation Date for Medicare Prior Authorization

The Centers for Medicare and Medicaid Services (CMS) recently updated its COVID-19 Reduction of Provider Burden Frequently Asked Questions (FAQ) document to provide updates on the resumption of Medicare audit activity and revised implementation dates for Medicare prior authorization of six lower limb prosthesis codes.

Resumption of Medicare Audits
The FAQ was updated to indicate that CMS has authorized Medicare contractors (e.g. DME MACs, RACS, SMRCs, etc.) to once again perform pre-payment and post-payment audits as part of their medical review responsibilities. CMS had suspended most audits as of March 30, 2020 due to the COVID-19 Public Health Emergency (PHE). In the updated FAQ, CMS indicates that due to the "importance of medical review activities to CMS' program integrity efforts, CMS expects to discontinue exercising enforcement discretion beginning on August 3, 2020, regardless of the status of the public health emergency." CMS indicates that if individual providers are selected for medical review believe that responding to a request for documentation will create a hardship situation, they should discuss response options with the contractor performing the review.
It is important to note that CMS authorized the reinstatement of all Medicare audits, not just audits of orthotic and prosthetic claims.

The timing of the resumption of audit activity is surprising considering that the PHE remains in effect and AOPA will be communicating our concern to CMS about the burdens that renewed audit activity will place on providers that are already operating under challenging circumstances.

Update on Medicare Prior Authorization
The updated FAQ also included new implementation dates for the Medicare Prior Authorization program for the six lower limb prosthesis codes (L5856, L5857, L5858, L5973, L5980, and L5987) that had their original implementation delayed due to the COVID-19 PHE. CMS announced that Medicare prior authorization for the six codes will begin in the four states previously selected for the initial roll out (PA, MI, TX, and CA) on September 1, 2020 and will be implemented nationally on December 1, 2020.

AOPA has developed resources to assist members to understand how the prior authorization process will work and what to expect from it. These resources, including live and on demand education opportunities will be made available to AOPA members soon.

View the updated CMS FAQ document.

CMS Releases New HCPCS Code: K1007

CMS and the Healthcare Common Procedural Coding System (HCPCS) workgroup has published the coding decisions from their inaugural biannual Durable Medical Equipment and Accessories; Orthotics, Prosthetics, and Supplies HCPCS code application review cycle.

As part of this first biannual code application review cycle CMS has released the new code K1007 (Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors). The K1007 will be effective for claims with a date of service on or after October 1, 2020.

Calling all AOPA Members, You Now Have FREE Access to AOPAversity

AOPA knows you and your employees are being tremendously impacted by COVID-19. To help, we are offering you, our AOPA members, the ability to access our online learning management system, AOPAversity, for **FREE** for the rest of 2020. It is our hope that this will make it easier to navigate the current unprecedented situation.

What does this mean? You and your employees can now access all 72 online offerings which are pre-recorded videos available on demand. That's 33 business offerings worth 34.5 Business Credits and 39 clinical offerings worth 60.5 Scientific Credits. **FREE.**

If you do not currently have an AOPAversity account, click here to create a profile. You will need your AOPA member ID and zip code affiliated with your membership when you create your profile to access the free offering. If you already have an AOPAversity account, log in here. Your username is the e-mail used to create your profile.

This offer is valid through December 31, 2020. It does exclude any refunds to purchases made prior to the start of this offer. We truly hope this offers you additional support during this uncertain time.

AOPA's COVID-19 Responses, Guidance, and Resources

To say we are in unprecedented times would be an understatement. Since my last message, the American Orthotic and Prosthetic Association (AOPA) leadership has continued to closely follow the coronavirus disease (COVID-19) and its widespread impacts. We have also been taking your calls and emails and hearing firsthand how extremely difficult and uncertain things are for you, your businesses, and your patients.

To that end, we are responding with support. We are responding with outreach to legislators about how they can best support the O&P profession. We are responding by providing guidance on regulations like documentation, telehealth, and stay at home orders. We are responding by pulling together resources. We are responding by creating a space on the Co-OP to share your experiences and strategies with one another.

All of this can be found on the newly developed **COVID-19 Response and Resources webpage**. We will be updating this webpage frequently with actions, guidance, and resources as well as pushing out updates via email, SmartBrief, and our social media channels.

Thank you for all you continue to do for your patients and the O&P profession. The Board and staff are here to support you so that you can do this. If you have questions, concerns, or needs do not hesitate to reach out to any of the staff at info@AOPAnet.org.

CMS Releases a Provider Toolkit of Resources Related to COVID-19

The Centers for Medicare & Medicaid Services (CMS) has released a Virtual Toolkit to help providers stay up-to-date on CMS materials available on COVID-19. The toolkit provides multiple links to valuable information for providers, caregivers, Medicare beneficiaries, and other CMS partners.

Upcoming Events

October 14, 2020	*New Technical Credits- Clinician's Corner: Fitters and Techs* AOPA Webinar Learn more and register
October 16, 2020	*Co-OP Tutorial* Learn more and register
November 9 and 10, 2020	*Virtual Coding and Billing Seminar* AOPA Seminar Learn more and register
November 11, 2020	*RAC Audits: What Are They Looking At?* AOPA Webinar Learn more and register