AOPA In Advance SmartBrief
February 16, 2021

AOPA Headlines:

New Post Payment Review for L0457, L0631, and L0650

Noridian, the DME MAC for jurisdictions A &D, recently announced that they will be conducting post-payment medical record reviews of claims for the following three HCPCS codes: L0457, L0631, and L0650.

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

2021 COPL RFP Now Open

The American Orthotic and Prosthetic Association (AOPA), in conjunction with the Center for Orthotic and Prosthetic Learning and Outcomes/Evidence-Based Practice (COPL) and its Board of Directors, is pleased to announce its 2021 Request for Pilot Grant Proposals. Proposals are being accepted in 10 areas of orthotic and prosthetic research including an open topic.

For 2021-2022, the association is seeking proposals at two funding levels for one-time grants, $15,000 and up to two exceptional proposals for $30,000 for one year. Preference will be given to grants that address evidence-based clinical application in orthotics and prosthetics. View the RFP topics and guidelines.

The deadline for all proposals is April 30, 2021. Apply online.

If you have any questions, please contact AOPA's Director of Strategic Alliances Ashlie White at awhite@AOPAnet.org or 571/431-0812.

HCPCS Code Changes Effective April 1, 2021

CMS recently released the coding decisions for each HCPCS code application processed in CMS' Second Biannual 2020 non-drug and non-biological items and services review cycle, which includes orthotics and prosthetics. The following new codes will be effective for claims with a date of service on or after April 1, 2021:

- K1014 -Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control
- K1015-Foot, adductus positioning device, adjustable

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

CMS Issues Medicare Coverage of Innovative Technology Final Rule

On January 12, CMS released the Medicare Coverage of Innovative Technology Final Rule. It's stated goal is to provide the nation's more than 60 million Medicare beneficiaries faster access to the latest medical technology by addressing the current lengthy processes that include required FDA approval of a device is followed by a separate process for Medicare coverage. AOPA will be tracking the implications of the rule and providing updates as appropriate. In the meantime, please go to My O&P Community and answer the question:

Do you currently use other payer's information in your appeals? This will help us in our analysis.

Final VA Rule on Prosthetics Published

The Prosthetic and Rehabilitative Items and Services Final Rule was published in the Federal Register and goes into effect on January 27, 2021. The proposed rule was published in October 2017. AOPA provided comments at that time.

The rule establishes and clarifies eligibility for prosthetic and rehabilitative items and services available to Veterans.

Previously the categories of prosthetic and orthotic services, sensory aids and medical devices the VA is authorized to provide to Veterans as part of their active treatment and ongoing rehabilitation varied across VA medical centers. AOPA has long communicated its concerns regarding such inconsistencies.

Of the rule, VA Secretary Robert Wilkie said, "The rule establishes a uniform approach for VA to deliver prosthetic items and services to Veterans. It ensures Veterans receive the same standard of service for the rehabilitative devices they need to live independently, no matter which medical center they walk into."

AOPA staff are in the process of creating a page on the Co-OP to help you better understand the policy requirements and documentation responsibilities of this rule so that you can best serve your Veteran patients. Specifically, we will be addressing the following sections of the policy:

- promote, preserve, and restore standard under § 17.38(b)
- direct and active component test in § 17.3230(a)
- medical necessity standards under §§ 17.38(b) and 17.3230(a)

Over the past several years AOPA staff have worked to increase collaboration and build stronger relationships with VA leadership. One product of these relationships is the development of dedicated VA education for AOPA members, which will be rolling out in 2021. This education will not only dive into the various policies and regulations, but will also provide guidance on how to best work with your local VA, specifically between contract providers and VA staff.

If you have questions about this issue please contact Justin Beland at jbeland@AOPAnet.org.

DoD Funding Opportunity

Department of Defense Orthotics and Prosthetics Outcomes Research Program Anticipated Funding Opportunities for Fiscal Year 2021. Although the Fiscal Year 2021 (FY21) Defense Appropriations Bill has been signed into law, the FY21 appropriation for the Department of Defense Orthotics and Prosthetics Outcomes Research Program (OPORP) is contingent upon the outcome of a pending rescissions request. The OPORP is providing the information in this pre-announcement to allow investigators time to plan and develop

ideas for submission to the anticipated FY21 funding opportunities. This pre-announcement should not be construed as an obligation by the Government. Learn more.

Draft Common Data Elements for Lower Limb Research RFI

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) is seeking input on common data elements (CDEs) related to lower limb loss. NICHD invites the public to comment on the draft Common Data Elements for Lower Limb Loss Research. AOPA will be coordinating with its Research Committee and Medical Advisory Board to draft comments for submission.

Public comments will be accepted by email to Rehabilitation1@mail.nih.gov.

Medicare Sequestration Based Reimbursement Reduction Suspended Through March 2021

The recently passed federal Covid-19 legislation included a provision that will continue the suspension of the 2% sequestration-based reduction in Medicare reimbursement through March 31, 2021. Medicare sequestration, originally passed in 2011, has resulted in a 2% reduction in reimbursement for Medicare fee for service claims. The original CARES Act legislation, Passed in March 2000 suspended sequestration-based reimbursement reductions through December 31,2000. The recently passed legislation extended the suspension of the 2% fee reduction through March 31, 2021. Medicare fee for service claims will continue to be reimbursed without the 2% reduction and AOPA will continue to work with our Congressional allies to further extend the suspension if necessary.

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

Reminders About Prior Authorization and Competitive Bidding

AOPA would like to remind O&P providers that effective for dates of service on or after January 1, 2021, products described by HCPCS codes subject to Medicare prior authorization (L5856, L5857, L5858, L5973, L5980, and L5987) must be code verified by PDAC. The PDAC DMECS system, which lists all current code verifications may be accessed by clicking HERE.

AOPA would also like to remind O&P providers that Medicare Competitive Bidding for 23 OTS spinal and knee orthosis codes went into effect for claims with dates of service on or after January 1, 2021. Only providers who were awarded contracts as part of the Medicare competitive bidding process may provide products described by one of the 23 OTS spinal and knee orthosis codes.

The OTS spinal codes subject to Medicare competitive bidding are L0450, L0455, L0457, L0467, L0469, L0621, L0623, L0625, L0628, L0641, L-0642, L0643, L0648, L0649, L0650, and L0651.

The OTS knee orthosis codes subject to Medicare competitive bidding are L1812, L1830, L1833, L1836, L1850, L1851, and L1852.

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

DMEPOS Fee Schedule Increased by 0.2%

The Centers for Medicare and Medicaid Services (CMS) has released the 2021 Medicare DMEPOS fee schedule which will be effective for Medicare claims with a date of service on or after January 1, 2020. As anticipated, the 2021 Medicare fee schedule for orthotic and prosthetic services will be increased by 0.2% over 2020 rates. The 0.2% increase is a net reflection of the 0.6% increase in the Consumer Pricing Index for Urban Areas (CPI-U) from June 2019 through June 2020, combined with the annual Multi-Factor Productivity Adjustment (MFP) of -0.4%.

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

2021 Medicare Part A & B Deductibles, Premiums, and Coinsurance Amounts Released

The Centers for Medicare and Medicaid Services (CMS) has recently announced the Medicare premium and deductible rates for 2021. The monthly Medicare Part B premium will begin at $148.50, and the Medicare Part B deductible has been set at $203.00.

The Medicare Part A deductible for 2021 is set at $1,484 and the daily co-insurance amount for days 61-90 is $371 and the lifetime reserve day's rate is set at $742. Lastly, the SNF Part A extended care days co-insurance (day 21-100) will be $185.50 for 2021.

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

Medicare to Allow Nurse Practitioners and Physician Assistants to Certify the Medical Need for Diabetic Shoes in Limited Circumstances

AOPA, in collaboration with other healthcare organizations, has actively supported the inclusion of nurse practitioners (NPs) and physician assistants (PAs) to serve as certifying practitioners under the Medicare diabetic shoe benefit. The Social Security Act states that the certifying physician must be the MD or DO that is managing the patient's systemic diabetic condition. This has led to significant access issues as the delivery of healthcare has evolved and non-physician practitioners have become more prevalent as primary care providers.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) recently announced two separate pathways that expand the ability of NPs and PAs to certify the medical need for diabetic shoes provided to Medicare beneficiaries.

The first pathway only applies to NPs and is being coordinated by the Center for Medicare and Medicaid Innovation through the Primary Care First (PCF) demonstration project. The PCF demonstration project will be implemented on January 1, 2021 and will run through December 31, 2025. NPs that are participating in the PCF demonstration project in one of the 26 states/regions that it will be implemented in may serve as the certifying practitioner for diabetic shoes covered by Medicare. The PCF model does not require the NP to operate under the direct supervision of a physician, but it does not apply to physician assistants. The announcement of the expansion of the role of NPs under the PCF demonstration project may be viewed HERE.

The second pathway is effective immediately and applies to both NPs and PAs that are providing healthcare services under the direct supervision of an MD or DO through "incident to" provisions. The DME MACs have indicated that CMS has offered guidance that allows NPs and PAs to certify the medical need for diabetic shoes when **ALL** the following conditions are met:

1. The supervising physician has documented in the medical record that the patient is diabetic and has been, and continues to provide, the patient follow-up under a comprehensive management program of that condition; and,
2. The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient; and,
3. The supervising physician must review and verify (sign and date) all of the NP or PA notes in the medical record pertaining to the provision of the therapeutic shoes and inserts, acknowledging their agreement with the actions of the NP or PA.

It is important to note that this pathway does not apply to NPs that are practicing independently (billing under their own NPI). They must be practicing under the direct supervision of an MD or DO. The announcement of the "incident to" clarification may be viewed HERE.

AOPA is encouraged by the announcements above and is pleased that CMS has acknowledged the expanding role of NPs and PAs in the delivery of primary healthcare. We will provide additional details on these policy changes as they become available.

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

CMS Introduces Single Payment Amounts for Medicare Competitive Bidding of OTS Knee and OTS Spinal Orthoses

On October 27, 2020, the Centers for Medicare and Medicaid Services (CMS) announced the Single Payment Amounts (SPAs) for select Off-the-Shelf (OTS) knee and OTS spinal orthosis codes included in the Medicare DMEPOS competitive bidding program scheduled for implementation on January 1, 2021.

AOPA has continually expressed a need for CMS to delay implementation of Round 2021of the Medicare DMEPOS competitive bidding program due to the COVID-19 Public Health Emergency (PHE). These efforts include but are not limited to multiple communications with high ranking CMS officials, coordination of advocacy efforts with AOPA partner organizations both within and outside of O&P, vocal support of congressional efforts, including a letter to CMS signed by more than 100 members of Congress requesting consideration of a program delay, and comprehensive discussions with key legislators on the importance of ensuring Medicare beneficiaries have access to high quality, clinically appropriate care, delivered by properly credentialed and accredited providers.

AOPA will continue to provide feedback to CMS through these and other channels. In addition, AOPA is still working to secure co-sponsors and congressional support for the Medicare O&P Patient Centered Care Act which includes a provision that, if enacted, would preserve patient access to OTS orthoses from certified and/or licensed orthotists and prosthetists by creating an exemption from the requirement to have a competitive bidding contract, similarly to physicians and other healthcare professionals. To support this legislative effort visit AOPAvotes.org.

While CMS removed several product categories from inclusion in Round 2021, it elected to move forward with competitive bidding for OTS knee and OTS spinal orthoses. The product categories removed from inclusion in competitive bidding by CMS represented product categories that have been part of the Medicare DMEPOS competitive bidding program in the past. Due to their inclusion in previous rounds of competitive bidding, SPAs were established nationally that resulted in significant savings to the Medicare program. New bids that were submitted as part of the Round 2021 competition for these product categories did not result in significant additional savings for the Medicare program. Because OTS knee and OTS spinal orthoses were not previously part of Medicare competitive bidding, the competition resulted in significant savings to the Medicare program over the three-year initial program length and the subsequent expansion of the SPAs into non-competitive bid areas.

In its announcement, CMS indicated that in a limited number of CBAs where competitive bidding did not result in significant savings to the Medicare program and therefore, competitive bidding for OTS orthoses will not be implemented. AOPA will be providing more information about these CBAs shortly.

If you elected to participate in the competitive bidding program for OTS knee orthoses, OTS spinal orthoses, or both, you will either be offered a contract effective for claims with a date of service on or after January 1, 2021 or you will receive a disqualification notice indicating that you will not be offered a contract. If you are offered a contract, you must accept or decline the contract offer by November 10, 2020. It is important to remember that if your previously submitted bid was found to be at or below the median composite bid rate and you decline a contract offer, you will forfeit your $50,000 bid surety bond. Your contract offer(s) will indicate whether your submitted bid was at or below the median composite bid rate. If you receive a disqualification notice and believe that you were disqualified incorrectly, you may submit a bidder inquiry through the DMEPOS competitive bidding website portal.

The SPAs for each competitive bidding area (CBAs) and detailed information regarding next steps may be found on the Medicare DMEPOS competitive bidding website here. The complete CMS announcement may be viewed here.

Questions regarding the Medicare DMEPOS Competitive Bidding Program can be directed to Devon Bernard at dbernard@AOPAnet.org or Joe McTernan at jmcternan@AOPAnet.org.

2021 Medicare O&P Fee Schedule Update

The Centers for Medicare and Medicaid Services (CMS) has published an update on the economic factors that are used to calculate the Medicare O&P fee schedule. The annual Medicare fee schedule increase for O&P services is based on a combination of change in the Consumer Pricing Index for Urban Areas (CPI-U) from June to June of the previous year combined with the annual Multi-Factor Productivity Adjustment (MFP).

CMS recently announced that the CPI-U for June 2019 through June 2020 is 0.6% and the annual MFP adjustment is -0.4% for a net increase of 0.2%. While CMS has not officially announced the 2021 update to the Medicare O&P fee schedule, the announcement of the CPI-U and MFP adjustment lead to relative confidence in the 2021 increase of 0.2%.

The 0.2% increase in the O&P Medicare fee schedule for 2021 is slightly lower than the 2020 increase of 0.9%. While the Medicare 2% sequestration-based reduction to all Medicare payments has been suspended through dates of service through December 31, 2020 as a result of the CARES Act, continued suspension of sequestration-based fee reduction will require additional legislative action. AOPA is following this issue closely and supports the continued suspension of sequestration-based fee reductions.

Questions regarding the 2021 Medicare fee schedule may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

Introducing AOPA Connection

Welcome to AOPA Connection, your one-stop-shop for all things AOPA.

Logging into AOPA Connection you will instantly have access to all your AOPA benefits, including:

- AOPAversity
- Your Membership Record
- Your Individual Profile
- Event Calendar
- Bookstore (including past purchases)
- Co-OP

But, it doesn't stop there! We are pleased to introduce a new benefit accessible through AOPA Connection, My O&P Community. In this online community of your O&P colleagues

you can get guidance, share advice, have one-on-one and group conversations, and access resources.

For Primary/Principal Member Contacts:

- For security reasons, we couldn't bring over passwords during conversion from our old database, so you get to start fresh. To access AOPA Connection click here and enter your unique email address to reset your password. Then, just follow the instructions for logging in. Note: accounts are tied to email addresses.
- If for some reason you are told your email is not found, create an account here.
- If, you had multiple emails addresses in the old database and receive this email to all accounts please contact us at info@AOPAnet.org and we will help you reconcile your accounts.
- Once logged in be sure to complete your profile, this will help us better meet your needs as well as allow others to connect with you. Once you do this, play around with all the features, re-familiarize yourself with all the AOPA benefits, check out the discussions happening in My O&P Community.
- You can set all your employees up with their own credentials so they too can access all the AOPA member benefits. Spread the word, send them here and tell them to setup an account using their unique email and follow the instructions to link to your organization's name.

For Employees of Members:

- Accessing AOPA Connection is simple, all you need to do is set up your account here using your unique email and follow the instructions to link to your organization's name.
- Once logged in be sure to complete your profile, this will help us better meet your needs as well as allow others to connect with you. Once you do this, play around with all the features, re-familiarize yourself with all the AOPA benefits, check out the discussions happening in My O&P Community.

To learn how to access and use AOPA Connection, watch Betty Leppin, Senior Manager of Membership demo AOPA Connection in this recording.

Questions? Check out these Tips for Logging In. Still have questions? Contact Betty Leppin at bleppin@AOPAnet.org or 571-431-0876.

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.

Upcoming Events

March 5 Co-OP Tutorial
Register

March 8 & 9 Virtual Coding and Billing Seminar
Register

March 10 Inpatient Billing: Working with Your Care Partners
Register