AOPA In Advance SmartBrief
March 18, 2021

AOPA Headlines:

Lower Limb Policy Updates

On March 18, 2021 the DME MACs released a revised version of the Lower Limb Prostheses Policy Article. In the Policy Article they provided new coding guidelines for two HCPCS codes, the L5968 (Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature) and L5986 (All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal). Here are the new coding guidelines:

- L5968 describes a product that is used as an addition to L-code foot systems for lower limb prosthesis construction. The product provides multiaxial motion in the coronal and sagittal plane from articulating components. At transition of stance phase to swing phase, the product will increase the ankle's dorsiflexion angle and maintain it throughout swing phase. The product provides an accommodation of changing heel heights without the user's input. The predicate product is the Rincoe R-Hab Ankle.

- L5986 describes a product that is used as an addition to L-code foot systems for lower limb prosthesis construction. The product provides multiaxial motion in all three planes of motion, sagittal, coronal, and transverse. This code does not describe the multiaxial motion achieved from the inherent flexibility of the prosthetic keel or a split keel/heel prosthetic foot design. The predicate product is a device that was manufactured by Medical Center Prosthetic, which is represented in the coding narrative by "MCP."

There have also been recent minor clerical updates to the Knee Orthosis Policy, the Diabetic Shoe Policy, the Spinal Policy, and the Orthopedic Shoe Policy.

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

Joint DME/PDAC Coding Bulletin Provides Clarification on Proper Billing of Prefabricated Orthoses

On March 11, 2021, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Pricing, Data Analysis, and Coding Contractor (PDAC) published a joint correct coding bulletin regarding code descriptors that include the term "prefabricated, includes fitting and adjustment".

In 2014, the Centers for Medicare and Medicaid Services (CMS) introduced a series of procedure code pairs that included both an off-the-shelf (OTS) version and a version that requires custom fitting by an individual with appropriate expertise and or training. A total of 51 orthotic HCPCS codes did not have their descriptors changed and continued to simply state, "prefabricated, includes fitting and adjustment." The March 11, 2021 coding bulletin indicates that HCPCS codes that include the term, "prefabricated, includes fitting and adjustment" are appropriately classified as custom fitted orthoses and therefore may only

be used to describe orthoses that require customization and/or modification by a certified orthotist or other properly trained individual. Orthoses described by these codes that are delivered as OTS, without customization and/or modification must be billed using the appropriate not otherwise specified code (L1499, L2999, L3999). The bulletin also emphasizes that, like all custom fitted codes, orthoses that are billed using one of the 51 HCPCS codes that include the term, "prefabricated includes fitting and adjustment" may not be shipped or mailed to Medicare beneficiaries without clear documentation of the customization and/or modification that was performed to ensure a proper fit.

AOPA continues to support the provision of orthoses by individuals with the appropriate clinical expertise, training, and relevant certification/licensure to ensure patients receive high quality, clinically appropriate care. AOPA is reviewing the correct coding bulletin and will provide constructive feedback to the DME MACs/PDAC.

View the correct coding bulletin.

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

Thank you 2021 Supplier Plus Partners

After Feedback from AOPA, DME MACs No Longer Require Brand Name Product Selection for Medicare Prior Authorization

In December of 2020, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) implemented Medicare prior authorization as a condition of claim payment for six lower limb prosthesis HCPCS codes (L5856, L5857, L5858, L5973, L5980, and L5987.) In addition to requiring prior authorization, effective for claims with dates of service on or after January 1, 2021, products described by the six codes above must be verified for correct coding by the Pricing, Data Analysis, and Coding Contractor (PDAC). So far, the Medicare prior authorization program has proven to be effective, efficient, and reasonable, with an average processing time of four business days for initial submissions, and a preliminary affirmation rate of higher than 50 percent for initial submissions and higher than 90 percent for resubmissions.

An issue that created concern among AOPA members was the inclusion of PDAC product verification as part of the Medicare prior authorization review process. The DME MACs were not issuing preliminary affirmation decisions without providers indicating the specific brand of prosthetic foot or knee they would deliver to the Medicare beneficiary.

AOPA engaged the DME MAC Medical Directors in very constructive and positive dialogue regarding the need for flexibility in product selection to best meet patients' clinical needs. AOPA explained that while classification of a patient's appropriate functional level often occurs during the early stages of clinical evaluation, the decision regarding the specific prosthetic components that best meet the patient's clinical needs within their assigned functional level is often made toward the end of the treatment process. While AOPA did

not challenge the concept of Medicare prior authorization, we respectfully requested the DME MACs reconsider the decision to require product selection as part of the process.

AOPA recently received a letter from the DME MAC Medical Directors in response to our concerns that, in part, stated the following:

"The DMDs understand that many variables can impact the selection of a specific brand-name product prior to delivery of the final prosthesis to a beneficiary. We do not prohibit substitution of another more suitable product, within the same HCPCS code that received provisional approval, at the time of delivery."

As a result of AOPA's outreach, the DME MACs have indicated that, after consultation with the Centers for Medicare and Medicaid Services , they will be removing the requirement for inclusion of product selection information in prior authorization submissions.

AOPA is pleased by this development that will ensure continued flexibility for product selection within the Medicare prior authorization program and is encouraged by the willingness of the DME MACs to engage in constructive and effective communication with AOPA on important issues.

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

You can also watch this video update from Joe McTernan.

Assistance Needed with University of Washington Study

A University of Washington research study, funded by AOPA and the U.S. Department of Defense, that aims to develop a new self-report survey instrument to measure mobility of lower limb orthosis users is recruiting participants.

Dr. Brian Hafner and his research team are looking for volunteers for the study. Interested individuals need to complete an online or paper survey that includes questions about an individual, their health, and their orthosis use. The survey takes anywhere from 30 to 60 minutes to complete and eligible participants will receive a $50 check by mail. A person is eligible to participate if they meet the criteria below:

- 18 years of age or older
- Ability to read, write, and understand English
- Ability to transfer, stand, or walk without the help of another person
- Use of an AFO, KAFO, HKAFO, or FES device for one or both legs
- Use of a lower limb orthosis for 6 months or longer

By producing a new assessment tool that can provide clinicians with meaningful information to guide patient care, this research has the potential to have a positive impact on the field of orthotics, . However, the success of this project depends upon assistance from O&P professionals to identify potential participants. Pleasel consider helping in one or more of the following ways:

- Reach out to patients (in-person, by phone, and/or by email)
- Post informational materials (posters, flyers, and/or pamphlets) in visible areas such as waiting areas and patient rooms
- Share information about the study through social media and/or newsletters

You should feel free to invite co-workers and office staff to mention this study to people who may be interested in participating. Please direct interested patients to visit the study website (www.mobilitysurvey.org) to learn more about the study and take the survey. To receive free informational materials by mail, please contact a research staff member at uwcorr@uw.edu or 1-800-504-0564.

Thank you for assisting with this research effort.

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 .

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

April 2 at Noon ET: Co-OP Tutorial

April 2: 2021 Assembly Call for Papers Closes

April 14 at 1pm ET: Pedorthic Clinician Corner

April 20-22, 27-29: 2021 Virtual Policy Forum

April 30: COPL RFP Closes