AOPA In Advance SmartBrief
October 26, 2021

AOPA Headlines:

AOPA Monitoring of and Communication with Government Officials Regarding the Release of Proposed Rules that will Require COVID-19 Vaccination

On September 9, 2021, the Biden Administration announced that the Occupational Safety and Health Administration (OSHA) and the Centers for Medicare and Medicaid Services (CMS) would be issuing independent Interim Final Rules that would require COVID-19 vaccination for employers with more than 100 employees (OSHA) and healthcare providers who are enrolled in Medicare and/or Medicaid (CMS). The White House indicated that these regulations were being drafted and were expected to be released in mid to late October 2021.

Since the White House announcement, AOPA has been closely monitoring and communicating with OSHA and CMS staff to ensure that we are prepared to communicate the requirements of the Interim Final Rules and the potential impact they may have on AOPA members. Given that we are at the end of October, we wanted to provide a brief update.

Through our dialogue with the CMS Office of Media Relations, we learned that CMS has been working closely with OSHA to ensure that, while separate, the proposed regulations will avoid unnecessary inconsistencies.

Recent media reports indicate that the OSHA Interim Final Rule has been forwarded to the White House Office of Management and Budget (OMB) for final review. This is usually the last step before publication in the Federal Register. Given this, the OSHA regulation is expected to be released soon. There has been no indication that CMS has submitted its Interim Final Rule to OMB, but it is expected that CMS will release its regulation around the same time of the OSHA release.

AOPA understands the significant impact that these regulations may have on your business and will provide a full summary of the regulations, including proposed compliance dates as soon as the Interim Final Rules are published.

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

HHS Applications Open for $25.5B in PRF Phase 4 and APR Funding for Healthcare Provider Pandemic Relief

On September 29th, the Health Resources and Services Administration (HRSA) made available $25.5 billion in new funding for healthcare providers affected by the COVID-19 pandemic.

Of this total, $17 billion will be paid out through Phase 4 of the Provider Relief Fund (PRF), based on providers' lost revenues and expenditures between July 1, 2020 and March 31, 2021. To ensure equity, smaller providers will be reimbursed at a higher rate than larger providers, and bonus payments at Medicare rates will be included for providers that serve Medicaid, Medicare, and/or CHIP patients.

The remaining $8.5 billion will be allocated through the American Rescue Plan (ARP) rural program. Payments will be distributed to providers based on the amount of Medicaid, Medicare, and/or CHIP services they provide to patients that live in rural areas, as defined by HHS's Federal Office of Rural Policy. Like the PRF Phase 4 bonus payments, ARP rural payments will generally be based on Medicare reimbursement rates.

To streamline the application process, providers will apply to both programs through a single application, which will use existing Medicaid, Medicare, and CHIP claims data to calculate payments. For more information about eligibility, required documentation, and the application process for the PRF and APR rural programs, click here.

Questions regarding this issue may be sent to Joe McTernan at jmcternan@aopanet.org, Devon Bernard at dbernard@aopanet.org, or Sam Miller at smiller@aopanet.org.

New HCPCS Code: K1022

Begging for claims with a date of service on or after October 1, 2021 there will be a new HCPCS code for lower limb prostheses, K1022 (Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type).

This new code is the result of a code application submitted during CMS' First Biannual 2021 HCPCS code application review cycle. The code application was submitted by Ottobock to describe the Ottobock 4R57 Rotation Adapter.

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

Thank You to Our 2021 National Assembly Sponsors

60 Day Grace Period Granter for Provider Relief Fund Reporting

The Health Resources and Services Administration (HRSA), the government agency responsible for administration of the COVID-19 Provider Relief Fund recently announced a 60 day grace period to allow providers additional time to file required reports relative to money received through the provider relief fund. The reporting deadline for funds received as part of the first round of funding (received between April 10 and June 30, 2020) remains September 30, 2021 but HRSA has announced that as long as the required reports are filed by November 30, 2021 no enforcement action will be taken.

As a reminder, providers who received more than $10,000 from the COVID-19 Provider Relief Fund are required to file reports that document that the money was used to support business operations during the COVID-19 public health emergency (PHE).

Detailed information regarding the reporting requirements and how to complete the reporting process may be found on the HRSA Provider Relief Fund website which may be accessed here.

AOPA recommends that members consult with their accounting professionals or financial advisors to ensure compliance with reporting requirements.

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

Certain Supplier Enrollment Activities to Resume in October

Beginning October 2021, CMS will resume certain provider enrollment activities that were paused during the COVID-19 public health emergency (PHE), including: Application Fees, Fingerprinting/Background Checks, and Revalidations.

Suppliers who missed their original revalidation date because of the PHE will be notified of their new revalidation due date in two ways, a letter will be sent to the correspondence address on file in the Provider Enrollment Chain and Ownership System (PECOS), and The Medicare Revalidation Tool will be updated to reflect the new date. The letters and revalidation tool site will be sent and updated at least 3 months in advance of the new revalidation due date.

If you were originally scheduled to revalidate your location(s)/PTAN(s) during the PHE you will want to keep an eye out for your revalidation letter and begin checking the revalidation tool website starting in October, because a failure to respond to the revalidation request by the revalidation due date, will result in the deactivation of your Medicare billing privileges.

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

TPE Audits to Resume

The Targeted Probe and Educate (TPE) program was temporarily suspended due to the COVID-19 Public Health Emergency (PHE), but the Centers for Medicare & Medicaid Services (CMS) has recently authorized the DME MACs to resume the TPE program. In resuming the TPE program the DME MACs should also be closing all post-payment reviews.

For a reminder on how the TPE program works visit the CMS TPE page.

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

QIC Telephone Discussion/Reopening Demonstration Project Ending

The Centers for Medicare & Medicaid Services (CMS) has issued a reminder, that all activities associated with the Qualified Independent Contractor (QIC) Telephone Discussion and Reopening Process Demonstration Project will be ending on December 31, 2021.

The demonstration project gave elected suppliers who submitted second level appeals (reconsiderations) to the QIC, currently the QIC for O&P claims is MAXIMUS, a chance to participate in a formal telephone discussion. These discussions allow suppliers to present additional information, documentation and facts about their appeal to support a favorable determination. The program has been very successful with approximately 70% of claims chosen for telephone discussion approved for payment versus only 30% of those not chosen for telephone discussion.

AOPA will continue to support programs that are designed to help suppliers and reduce the backlog of appeals at the Administrative Law Judge level. AOPA is currently with several other associations to engage CMS and the QIC to ensure that this valuable demonstration

project is extended or made permanent. The demonstration project has been extended once, as it was originally intended to end on December 31, 2020.

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

We Need Your Help, Ask Your Members of Congress to Support the Medicare O&P Patient-Centered Care Act

The Medicare O&P Patient-Centered Care Act (S. 2556) was introduced in the Senate. This bipartisan legislation would improve access to, and quality of, orthotic and prosthetic care while simultaneously combating fraud and abuse. The bill is identical to legislation introduced in the House in March.

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

In addition to asking your Senators to sponsor the Medicare O&P Patient-Centered Care Act, please also take a few minutes to reach out to your Representative following the same steps and ask them to support H.R. 1990 if they aren't already.

Finally, as you are using the AOPAvotes platform to send letters to your Senators and Representatives, be sure to utilize the automated Twitter campaign. Every Member of Congress has a Twitter account making it a great way to ask for their support.

Doing these three things will take just a few minutes and will go a long way in securing passage of this legislation. If Members of Congress do not hear from you, they will not know how important this legislation is to your businesses and more importantly, your patients

If you have any questions, contact Ashlie White AOPA's Director of Health Policy and Strategic Alliances, at awhite@AOPAnet.org.

Thank you for your efforts, they really do make a difference!

TAKE ACTION

PDAC Coding Verification: Prosthetic Hands & Articulating Digits

The DME MACs and PDAC have just released guidance requiring coding verification for products/items described by HCPCS codes L6715 (Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement) and L6880 (Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)). Effective for claims with a date of service on or after January 1, 2022 only products/items which have been verified and listed on the PDAC Product Classification List (PCL) may be billed to Medicare.

Manufacturers with items/products described by codes L6715 and/or L6880 should submit their products/items for verification review to the PDAC by August 31, 2021.

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

DME MACs Expand Medical Review on a Post-payment Basis

As a result of the COVID-19 public health emergency (PHE) the DME MACs had limited their post-payment reviews to focus on claims with dates of service prior to the beginning of the PHE on March 1, 2020. CMS has announced that Medicare Administrative Contractors, including the DME MACs, will now conduct post-payment reviews for later dates of service, including those after the declaration of the PHE. There is still no announced timeframe for the renewal of pre-payment audit activity through the Target, Probe, and Educate (TPE) program.

AOPA has contacted the DME MACs and has confirmed that post-payment reviews for dates of service during the PHE will take into account any policy waivers and regulatory flexibilities that were put in place by CMS to reduce provider burden but all applicable statutory, regulatory and coding and billing requirements will be subject to review.

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

CMS Updates System Edits for Custom Fabricated and Custom Fitted Orthoses

On May 20, 2021, the Centers for Medicare and Medicaid Services (CMS) issued updated program instructions to the DME MAC contractors that will result in the creation of additional Medicare claim edits in the 17 states that currently require licensure and/or certification of orthotists and prosthetists.

The updated claim edits will be implemented on October 4, 2021. In the 17 states that currently require licensure/certification, Medicare will only pay claims for custom fabricated orthoses (OR01) or custom fitted orthoses (OR02) when they are furnished by a provider that is enrolled under one of the following provider specialties:

- Medical Supply Company with Orthotics Personnel – Specialty Code 51;
- Medical Supply Company with Prosthetics Personnel – Specialty Code 52;
- Medical Supply Company with Orthotics and Prosthetics Personnel – Specialty Code 53;
- Orthotics Personnel – Specialty Code 55; • Prosthetics Personnel – Specialty Code 56;
- Orthotics Personnel, Prosthetics Personnel, and Pedorthists – Specialty Code 57;
- Physical Therapist – Specialty Code 65;
- Occupational Therapist – Specialty Code 67;
- Pedorthic Personnel - Specialty Code B2;
- Medical Supply Company with Pedorthic Personnel - Specialty Code B3;
- Ocularist – Specialty Code B5

The updated program instructions are consistent with the legislative requirements of the Benefits Improvement and Protection Act (BIPA) of 2000, the implementation of which AOPA has supported since passage.

While most AOPA members are enrolled in Medicare under one of the qualifying specialty codes above, it may be in your best interest to confirm your enrollment classification with the National Supplier Clearinghouse.

The CMS program instruction may be accessed here.

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

PDAC Product Classification List Process Change

Manufacturers/distributors are reminded that they must submit a Code Verification Review Application to the PDAC if they are looking to update any product information already listed on the PDAC Product Classification List.

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

Medicare Sequestration Suspension Extended Through the Remainder of 2021

The 2% sequestration-based reduction in Medicare reimbursement has been suspended for the remainder of the year. The sequestration suspension technically expired on March 31, 2021 but there was bi-partisan support to continue suspension of sequestration to reduce the burden on providers so they can focus on delivering necessary healthcare services.

As part of the anticipated extension CMS has instructed its contractors, including the DME MACs to hold claims with a date of service on or after April 1, 2021. With the extension now in place the DME MACs will release any previously held claims with dates of service on or after April 1, and will reprocess any claims paid with the reduction applied.

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

Corrections to the 2021 DMEPOS Fee Schedule

CMS recently announced that they have identified, and corrected errors found in the 2021 DMEPOS fee schedule. Claims which were submitted prior to January 26, 2021 with dates of service on or after January 1, 2021 may have been affected. The list of HCPCS codes which included errors and were correct didn't contain any orthotic and prosthetic codes. The complete list of codes affected and corrected maybe downloaded here.

Most of the corrections to the fee schedule amounts were minor and resulted in an increase of less than 1%. However, there may be a small percentage of claims were corrections resulted in changes that range from a 2021 fee schedule amount decrease of 30% to a 2021 fee schedule amount increase of 57%. The majority of these large increases/decreases were for claims submitted with the KE modifier, which does not apply to O&P claims.

If you provided any items included on the complete list of codes impacted by the corrections, you may contact your DME MAC and request them to reprocess and adjust all your claims accordingly.

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

Post Pay Review for Replacement Sockets

CGS, the DME MAC for jurisdictions B and C, has recently announced that they will be conducting post payment reviews for select replacement sockets. The two socket replacement codes selected for review are:

- L5700- Replacement, socket, below knee, molded to patient model
- L5701- Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model

Read the full announcement from CGS.

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

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.

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.

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.

Upcoming Events

November 8-9: Coding and Billing Seminar

November 10: Clinicians Corner – Orthotics

November 18: AOPA Advocacy in Action