



American
Orthotic &
Prosthetic
Association

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Final Phase of Prior Authorization for Select Orthoses Begins October 10

As a reminder Phase III, the final phase, of Prior Authorization for the following five orthoses:

- L0648 Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
- L0650 Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Lateral Strength Provided By Rigid Lateral Frame/Panel(S), Produces Intracavitary Pressure To Reduce Load On Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
- L1832 Knee Orthosis, Adjustable Knee Joints (Unicentric Or Polycentric), Positional Orthosis, Rigid Support, Prefabricated Item That Has Been Trimmed, Bent, Molded, Assembled, Or Otherwise Customized To Fit A Specific Patient By An Individual With Expertise
- 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

Will begin in all remaining states and territories for all claims with a date of service on or after October 10, 2022.

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

CO-261 Claim Rejections Resolved

Several AOPA members had reported having an issue with select lower limb prosthetic claims being rejected with the remark code CO-261 (The procedure or service is inconsistent with the patient's history). Since the claims were rejected and not denied the claim could not be appealed; it could only be fixed and resubmitted. However, there was no information or directions provided as to what was "inconsistent", and how it could be fixed. This inability to fix/appeal the claims was also causing some members to miss their timely filing window.

AOPA, over the last several months, has been working diligently with key staff members at the DME MACs, the DME MAC Medical Directors and high-ranking CMS officials to find a

reasonable solution and provide a pathway for suppliers to appeal these rejections; especially for those who may have missed their timely filing windows. The DME MAC Medical Directors recently [informed AOPA that the issue has been resolved](#), and that they will be contacting the affected suppliers and provide them with directions on how to resubmit and/or appeal their claims.

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

AOPA to Respond to Request from CMS Input on Improving the Medicare Advantage Program

On August 1, 2022, the Centers for Medicare and Medicaid Services (CMS) published a *Request for Information on Medicare* that seeks input from the public regarding actions that CMS can take to improve various aspects of the Medicare Advantage program. The notice, published in the Federal Register, seeks input from stakeholders and the public in the following five specific areas of the Medicare Advantage Program:

- Advancing Health Equity
- Expansion of Access: Coverage and Care
- Driving Innovation to Promote Person-Centered Care
- Supporting Affordability and Sustainability
- Engaging Partners

Medicare Advantage, also known as Medicare Part C, is a partnership between CMS and private insurance companies that allows private payors to offer healthcare services to Medicare beneficiaries as a replacement for their traditional fee-for-service Medicare benefits. Medicare Advantage plans must, at a minimum, offer the same benefits that a patient has access to under traditional fee-for-service based Medicare but may offer additional benefits such as vision or dental benefits. In addition, Medicare advantage plans typically offer services at a reduced cost-sharing expense to the beneficiary.

The Request for Information is an excellent opportunity to provide valuable input to CMS on how they can make definitive improvements to the Medicare Advantage program that will facilitate your organization's ability to provide the best O&P care to your patients enrolled in Medicare Advantage plans. AOPA will be submitting comments on behalf of its members, but encourage you to provide your own input based on your individual experience as well.

The August 1, 2022 Federal Register notice may be accessed [here](#). Comments will be accepted until August 31, 2022 and may be submitted electronically, by regular mail, or by express or overnight delivery. Instructions on how to submit your comments are available in the Federal Register notice.

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

**Microprocessor Knee Class Action Settlement with Anthem set for August 29,
2022 Final Approval Hearing**

In October 2021, AOPA reported a preliminary settlement that had been reached in the class action suit, *Lacy Atzin v. Anthem UM Services Inc. et al.* The preliminary settlement agreement resulted in a change to the previous Anthem policy for microprocessor prosthetic knees that required prosthetic patients to demonstrate that they could use the microprocessor knee to walk at variable cadence and to walk faster than normal walking speed. The revised policy, which has now been in effect for several years focuses more on the ability of the microprocessor knee to assist patients facilitate their activities of daily living.

The settlement has been agreed to by all involved parties, including representatives of Anthem Blue Cross & Blue Shield and attorneys representing the class of plaintiffs. The U.S. District Court for the Central District of California will formally approve the settlement in a hearing scheduled for August 29, 2022.

More information regarding the class action suit including how claims for previously denied services may be submitted may be found [here](#).

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

Reminder: Sequestration Amount to be Increased to 2%

Be advised that the current partial 1% sequestration reduction applied to your final Medicare payment amounts officially ends on June 30, 2022. Beginning on July 1, 2022 you will begin to see the full sequestration amount of 2% applied to your final Medicare payment amounts.

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

OIG Releases Report on Medicare Advantage Plan Denials of Prior Authorization Requests

On April 28, 2022, the Department of Health and Human Services Office of Inspector General (OIG) released a report entitled *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*. The report indicated that in many instances, the OIG determined that Medicare Advantage Organizations (MAOs) inappropriately denied prior authorization requests that impacted Medicare beneficiaries' access to medically necessary care. The OIG highlighted the following key takeaways in its report.

“MAOs denied prior authorization and payment requests that met Medicare coverage rules by:

- using MAO clinical criteria that are not contained in Medicare coverage rules;
- requesting unnecessary documentation; and
- making manual review errors and system errors.”

The OIG report included a sample of five hundred prior authorization requests denied by various sized MAOs across the full spectrum of Medicare covered services. The report included a representative sample of some of the prior authorization denials that were identified including several examples of claims involving DMEPOS services. While no O&P prior authorization denials were specifically identified in the report, the findings and recommendations of the report remain significant. The OIG reported that of the prior authorization denials that were reviewed, 13 percent met Medicare coverage requirements and 18 percent met both Medicare and MAO coverage requirements. In both scenarios, the OIG reported that the prior authorization requests should not have been denied by the MAO.

As a result of its investigation the OIG made the following three recommendations to the Centers for Medicare and Medicaid Services (CMS).

- issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews;
- update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types; and
- direct MAOs to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

CMS concurred with all three OIG recommendations.

AOPA is encouraged that the OIG and CMS remain committed to ensuring Medicare beneficiaries have access to medically necessary, clinically appropriate care, including O&P services and supports the recommendations in the OIG report. Medicare beneficiaries will benefit from increased oversight of MAOs and additional guidance from CMS regarding MAO adherence to Medicare coverage policies.

Access the [OIG report](#).

Questions regarding the OIG report may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

Written Order Prior to Delivery & Face-to-Face Encounter Reminder

As a reminder, effective for dates of service on or after April 13, 2022 CMS requires a Written Order Prior to Delivery (WOPD) and documentation of a Face-to-Face encounter

with a qualified practitioner within 6 months prior to delivery to be on file for the following HCPCS codes: L0648, L0650, L1832, L1833, L1851 and L3960.

This requirement is independent of the Medicare prior authorization requirement that also began in New York, Illinois, Florida and California on April 13, 2022. As a condition of payment, claims for L0648, L0650, L1832, L1833, L1851 and L3960 that are submitted without the WOPD and Face-to-Face encounter will be denied.

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

AOPA Impacts CMS Guidance Regarding Medicare Prior Authorization for Emergent Need Orthoses

In January 2022, the Centers for Medicare and Medicaid Services (CMS) announced the expansion of the Medicare prior authorization program to include the following five spinal and knee orthosis codes, L0648, L0650, L1832, L1833, and L1851.

While the existing Medicare prior authorization program for select lower limb prosthesis codes has been very successful to date, AOPA heard significant concerns from members regarding challenges that will occur obtaining Medicare prior authorization in situations where there is an immediate need to provide an orthosis to stabilize an injured or unstable spine or knee.

To address these concerns, AOPA immediately engaged the DME MACs and high-level CMS officials regarding the negative impact Medicare prior authorization for emergent need orthoses would have when there was an immediate need for an orthosis and suggested potential solutions to allow Medicare beneficiaries access while ensuring adequate protection of Medicare funds.

On April 12, 2022, CMS released guidance consistent with AOPA's recommendations. The CMS guidance stated that if the two-day expedited review process would delay care and risk the health or life of the beneficiary, the Medicare prior authorization requirement will be suspended. Claims for emergent need orthoses that would otherwise require Medicare prior authorization must be submitted with a "ST" modifier. While the ST modifier will allow claims to be processed and paid, all claims submitted with the ST modifier will then be subject to pre-payment review.

View the [full guidance](#) released by CMS.

As a reminder, Phase I of the expanded Medicare prior authorization program is in effect in New York, Illinois, Florida, and California for dates of service on or after April 13, 2022.

If you have any questions, contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org

DME MAC/PDAC Correct Coding Bulletin on Upper Extremity Prostheses

On Thursday, March 31 the DME MACs and the PDAC released a comprehensive correct coding bulletin for all Upper Extremity Prostheses (UEP). In the bulletin they stated that the correct coding of an UEP base code, addition codes, are dependent on two main factors: the level of amputation and the prostheses' power source.

The bulletin incorporates information from previous DME MAC/PDAC correct coding reminders, such as the one for [Articulating Digits and Prosthetic Hands](#), but also includes additional information on the proper coding of all aspects of the including: cable systems, suspension systems, and test sockets.

You may review the full UEP coding reminder [here](#).

AOPA with the help of its Coding & Reimbursement Committee and prosthetic manufacturers is currently reviewing this bulletin to determine how it will impact our membership and will provide all appropriate comments and feedback to the DME MACs and the PDAC.

We would also appreciate you sharing your feedback and concerns with us via My O&P Community or info@AOPAnet.org.

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



and

UEP

Prior Authorization for Select Orthoses Reminder

If you have patients who reside in California, Michigan, Pennsylvania, or Texas and you will be delivering an L0648, L0650, L1832, L1833 or L1851 on or after April 13, 2022 you must submit a Prior Authorization request as a condition of payment to your DME MAC. Suppliers in those states may begin to submit prior authorization requests on March 30, 2022 in anticipation of a April 13, 2022 delivery.

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

AOPA Re-Imagined

The American Orthotic and Prosthetic Association today announced its re-imagined brand, vision, mission, and strategic priorities that better align with its work and goals.

To appropriately represent the desired future for the organization, AOPA established the vision that truly embodies what AOPA members do each and every day, *A world where orthotic and prosthetic care transforms lives.*

When it came to the mission, the pillars of advocacy, research, and education were still important, but needed to be better articulated. That led the new mission, A trusted partner, advocating for and serving the orthotic and prosthetic community by:

- Fostering relationships with decision makers to ensure equitable access.
- Providing education that promotes professional excellence.
- Supporting research that informs innovative care.
- Advancing equality to strengthen the orthotic and prosthetic profession and improve the lives of patients.

Although created by the Board and staff the strategic priorities came out of feedback from members and the profession, they set the course for AOPA's future and lay out six areas that AOPA will work to accomplish in the next three to five years:

- Communicating the importance of orthotic and prosthetic care
- Increasing patient access to clinically appropriate, evidence-based care
- Helping members succeed in the changing healthcare environment
- Identifying and influence trends and learning that may impact orthotics and prosthetics
- Enhancing AOPA value, engagement, and community
- Driving collaboration by creating strategic relationships

The Board and staff will be regularly communicating the progress to its membership.

With all of this there became a need to design a visual identity that reaffirms and elevates AOPA's position as the leading voice of a progressive, solutions-oriented industry that is an integral part of enhancing lives and maximizing human potential. Additionally, orthotics and prosthetics are customized to meet the individual's unique needs. AOPA is as committed to meeting the needs of our members as you are to meeting the individual needs of your patients. That's the mark of an O&P professional. And AOPA's new logo* embodies this and signals a new era.

*To use AOPA's logo new logo contact info@AOPAnet.org.

Noridian Correcting Sequestration Error

AOPA was notified by members that Noridian was incorrectly applying the 2% sequestration reduction to claims with a date of service on and after January 1, 2022. AOPA reached out to Noridian to inquire about the reductions, and they agreed that the reductions were done in error and that they will automatically adjust any affected claims.

As a reminder the moratorium on the 2% sequestration reductions runs through March 31, 2022, and then a 1% sequestration will be applied to claims through June 30, 2022.

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

CMS Expands its Prior Authorization Program and Adds O&P Codes to the Master List of Codes Subject to Face to Face Encounters and Written Orders Prior to Delivery

On January 12, 2022, the Centers for Medicare and Medicaid Services (CMS) announced several updates to the Master List of DMEPOS items potentially subject to face-to-face encounter, written order prior to delivery, and prior authorization requirements. The Federal Register announcement (CMS-6081-N) added the following five O&P HCPCS codes to the Master List:

L0830 Halo Procedure, Cervical Halo Incorporated Into Milwaukee Type Orthosis
L1005 Tension Based Scoliosis Orthosis And Accessory Pads, Includes Fitting And Adjustment
L1906 Ankle Foot Orthosis, Multiligamentous Ankle Support, Prefabricated, Off-The-Shelf
L2580 Addition To Lower Extremity, Pelvic Control, Pelvic Sling
L2624 Addition To Lower Extremity, Pelvic Control, Hip Joint, Adjustable Flexion, Extension, Abduction Control, Each
L7368 Lithium Ion Battery Charger, Replacement Only

The following O&P code was removed the Master List:

L3761 Elbow Orthosis (EO), With Adjustable Position Locking Joint(s), Prefabricated, Off-The-Shelf

It is important to note that inclusion of a HCPCS code in the Master List does not mean that it is automatically subject to face-to-face encounter, written order prior to delivery, and prior authorization requirements; inclusion in the Master List only allows CMS to select the code for one or all these requirements in the future.

CMS-6081-N also announced that the following six O&P HCPCS codes will require a Face-to-Face Encounter and Written Order Prior to Delivery as a condition of payment for claims with a date of service on or after April 13, 2022:

L0648 Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
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L0650 Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Lateral Strength Provided By Rigid Lateral Frame/Panel(S), Produces Intracavitary Pressure To Reduce Load On Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L1832 Knee Orthosis, Adjustable Knee Joints (Unicentric Or Polycentric), Positional Orthosis, Rigid Support, Prefabricated Item That Has Been Trimmed, Bent, Molded, Assembled, Or Otherwise Customized To Fit A Specific Patient By An Individual With Expertise
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
L3960 Shoulder Elbow Wrist Hand Orthosis, Abduction Positioning, Airplane Design, Prefabricated, Includes Fitting And Adjustment

Finally, CMS-6081-N added the following 5 O&P HCPCS codes to the list of codes that will require Medicare Prior Authorization:

L0648 Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L0650 Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Lateral Strength Provided By Rigid Lateral Frame/Panel(S), Produces Intracavitary Pressure To Reduce Load On Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
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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

Medicare prior authorization for these five codes will be implemented in three phases. Phase 1 includes New York, Illinois, Florida, and California and begins on April 13, 2022.

Phase 2 adds Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington and begins on July 12, 2022. Phase 3 includes all remaining states and territories and begins on October 10, 2022.

AOPA is performing an in-depth analysis of the expansion of these programs but some initial thoughts regarding the potential impact are below:

- The five orthotic codes above represent expansion of Medicare prior authorization beyond the six lower limb prosthesis codes (L5856, L5857, L5858, L5973, L5980, and L5987) that have been subject to prior authorization since 2020.
- The five codes that will require prior authorization as part of the new process (two spinal and three knee orthoses) are all codes that have high utilization patterns and have been identified as having high potential for fraud and abuse
- Four of the five orthosis codes that are included in the expanded list of codes subject to prior authorization are included in the Medicare DMEPOS competitive bidding program.
- A concern about subjecting the five orthosis codes to Medicare prior authorization is that these orthoses often are needed immediately to stabilize an injured and unstable spine or knee. Requiring prior authorization may be challenging due to the acute nature of treatment with these orthoses.

AOPA will work with CMS and the DME MACs to ensure a smooth transition of these HCPCS codes into the Medicare prior authorization program.

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

AOPA is Pleased to Introduce the COMET

The Clinical Outcome Measures Electronic Toolkit (COMET) provides a database of validated outcome measures geared towards prosthesis and orthosis users and practitioners. It was developed by Orthocare Innovations, LLC in coordination with AOPA and with the support of a Center for Orthotic and Prosthetic Learning and Outcomes/Evidence-Based Practice (COPL) Pilot Grant.

COMET simplifies and standardizes the use of outcome measures in daily clinical practice to inform evidence-based clinical care. Practitioners using COMET are able to easily select the appropriate measure, administer a test, and immediately receive the result.

Using COMET, practitioners can:

- Justify and document effectiveness of P&O treatments
- Easily record and score treatment outcome measures
- Export PDFs to include in medical records (See [example](#))

Using it is easy! Start by selecting one or multiple outcome measures for your patient to complete. After your patient completes the measures, COMET instantly calculates the

scores and automatically generates a results report that can be exported as a PDF for inclusion in the electronic patient health record or where external documents are supported or needed.

It includes timed metrics such as the Timed Up and Go, patient-reported outcomes such as the Socket Comfort Score and Lower Extremity Functional Scale, and surveys such as the Patient Satisfaction Questionnaire.

COMET is now available! To use the mobile app, visit the [Google Play store](#) or [App store for iOS](#) to download.

Questions? Contact Dr. David Boone at dboone@orthocareinnovations.com.

Upcoming Events

October 17 – December 18

2022 Virtual National Assembly

[Register](#)

November 7-8

Virtual Coding and Billing Seminar

[Register](#)

November 9

The Do's & Don'ts of Gift Giving

[Register](#)

[See AOPA's Education Calendar](#)