AOPA In Advance SmartBrief
December 20, 2022

AOPA Headlines:

Medicare DMEPOS Fee Schedule Will See its Largest Annual Increase in 2023

New National Provider Enrollment Contractors

Help us make transhumeral prostheses better!

An Important Update on the Medicare O&P Patient-Centered Care Act

Final Phase of Prior Authorization for Select Orthoses Begins October 10

CO-261 Claim Rejections Resolved

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

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

Reminder: Sequestration Amount to be Increased to 2%

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

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

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

DME MAC/PDAC Correct Coding Bulletin on Upper Extremity Prostheses

AOPA Re-Imagined

AOPA is Pleased to Introduce the COMET

Upcoming Events

Medicare DMEPOS Fee Schedule Will See its Largest Annual Increase in 2023

The Centers for Medicare and Medicaid Services (CMS) has officially released the 2023 DMEPOS Medicare fee schedule and it has increased by 8.7%, this is larger than any annual Medicare increase in the last several decades.

The annual increase to the Medicare O&P fee schedule is based on the annual change to the Consumer Pricing Index for all urban areas (CPI-U) from June to June of the previous year adjusted by an annual productivity adjustment (MFPA) or Total Factor Productivity (TFP). The CPI-U from June 2021 to June 2022 was 9.1%. The MFPA or TFP for the 2023 DMEPOS Medicare fee schedule was 0.4%. So, when the 9.1% increase in the CPI-U is reduced by the 0.4% increase in the MFPA or TFP the results are a total net increase of 8.7% in the DMEPOS fee schedule for 2023.

Questions regarding the 2023 Medicare DMEPOS Fee Schedule may be directed to Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

New National Provider Enrollment Contractors

Prior to November 6, 2022, there was only one contractor handling all enrollments and revalidations for durable, medical equipment, prosthetic, orthotic and supplies (DMEPOS) suppliers; and that was the National Supplier Clearinghouse (NSC) . Palmetto GBA had the contract to be the NSC contractor. As of November 7, 2022 there are now two National Provider Enrollment (NPE) contractors handling enrollment and revalidation activities for DMEPOS suppliers, and each contractor is handling a different region.

Novitas Solutions will handle all suppliers in the eastern part of the United States including Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, District of Columbia, Puerto Rico, US Virgin Islands; and will be referred to as National Provider Enrollment (NPE) East. Novitas Solutions website for NPE East is: www.novitas-solutions.com/webcenter/portal/DMEPOS.

Palmetto GBA will continue to handle all suppliers in the western part of the United States including Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands; and will be referred to as National Provider Enrollment (NPE) West. You may still use the old National Supplier Clearinghouse website for Palmetto GBA to access information about NPE West or you may use the new site www.palmettogba.com/palmetto/npewest.nsf.

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

Help us make transhumeral prostheses better!

A research team at the Technical University of Munich is working on a novel transhumeral prosthesis design and needs your help.

Their goal is to develop a system with improved comfort and usability.

They are looking for individuals with an upper limb amputation or congenital limb malformation at the humerus level to provide feedback on their concept.

If you fit this description and are interested in helping, please follow this link to participate in our short (~15 minute) survey: https://www.soscisurvey.de/tum-mirmi/?r=aopa

Questions may be directed to Elisabeth Jensen elisabeth.jensen@tum.de.

An Important Update on the Medicare O&P Patient-Centered Care Act

We have been hard at work to get this legislation passed this year and are hopeful that the bill will be included in an end of year package. To make this happen, we continue to work with our champions in Congress to move the bill forward, including the very important step of requesting a financial impact analysis from the Congressional Budget Office. This work being done by our Senate champions is a critical step for it to be included in an end of year package.

During our conversations in the past couple of months, it was determined that the best way to get the legislation passed is to move it forward solely with its three core provisions: refining restoring the Congressional definition of minimal self-adjustment, expansion of the competitive bidding exemption to include Orthotists and Prosthetists, and the prohibition of drop shipping for non-OTS orthoses. Our champions in the House and Senate agree with this approach of taking the path of least resistance in removing elements of the Bill that might slow progress this Congress, without compromising the integrity of the legislation.

Distinguishing O&P from DME remains a top priority for AOPA and we remain committed to this provision. Although it needed to be removed from the Medicare O&P Patient Centered Care Act, we will continue to explore other ways, whether legislatively, through regulatory channels, or other approaches that might be appropriate, to accomplish this goal on behalf of our profession.

Thank you all for your support of this legislation, it has helped get us to this point. Please stay tuned for what you can do next to help get this legislation passed.

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 know 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, and 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 UEP 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.

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*.

American Orthotic & Prosthetic Association

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.

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

January 10
What's Your WHY? How to Create Brand Value: Branding Yourself and Your Company
Register

See AOPA's Education Calendar