



American Orthotic & Prosthetic Association

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AOPA In Advance SmartBrief
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February 11, 2020

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2020 Call for RFP Now Open

The American Orthotic and Prosthetic Association (AOPA), working 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 [2020 Request for Pilot Grant Proposals](#) in 10 potential areas of orthotic and prosthetic research, including an open topic.

For 2020-2021, the association and COPL are 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, 2020. [Apply online.](#)

If you have any questions, please contact AOPA's director of strategic alliances, Ashlie White at awhite@AOPAnet.org or call 571/431-0812.

AOPA Participates in CMS Listening Session on Contractor Operational Performance

On January 29, 2020, AOPA staff participated in a CMS listening session that was designed to receive provider feedback on the operational performance of Medicare Administrative Contractors (MACs). The session was introduced by CMS Administrator Seema Verma and was moderated by Larry Young, the Director of the CMS Medicare Contractor Management Group. The 60-minute session provided a brief background on the roles and responsibilities of the MACs, a discussion of general MAC performance based on CMS metrics, and then was opened to allow participants to provide feedback on opportunities for the MACs to improve their performance and enhance their interaction with providers.

AOPA submitted written comments in advance of the listening session that encouraged CMS to fully implement the qualified provider provisions outlined in section 427 of the Benefits Improvement Act of 2000 and allow the DME MACs to incorporate those provisions into its claims processing activities. AOPA's comments also encouraged CMS to provide clear instructions to the DME MACs regarding the inclusion of orthotist's and prosthetist's clinical notes as part of the patient's medical record for medical review purposes.

AOPA continues to support open dialogue with CMS and the DME MACs with the goal of achieving fair and equitable treatment of O&P providers and ensuring that Medicare beneficiaries continue to have access to high quality, clinically appropriate orthotic and prosthetic care.

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

AOPA Virginia House of Delegates HB 503 Testimony

Yesterday, at the request of Virginia Orthotic & Prosthetic Association, AOPA staff joined the Amputee Coalition to testify in front of the Labor and Commerce subcommittee of the Virginia House of Delegates in support of HB 503. This bill (first introduced in 2019) would mandate health insurance coverage for mechanical, bionic prosthetics that have a Medicare code under all Virginia state regulated health plans.

AOPA testified that, "The existing Insurance Fairness law has made it possible for Virginians living with limb loss and limb difference to receive care that would have otherwise been arbitrarily denied or capped, but it does not extend this guarantee of coverage to the most vulnerable individuals in our community. It also fails to secure access for patients to the most medically appropriate prosthetic devices for the restoration of mobility. Passage of this Bill will rectify these shortcomings."

[Read the full AOPA testimony.](#)

[Watch the AOPA testimony.](#)

Following the hearing the legislation was recommended to be continued to the next session, upon the recommendation that the Health Insurance Reform Commission (HIRC) continue to review the impacts of the Bill, per its mandate.

The Senate companion bill, SB 382 passed out of the subcommittee and is now on the docket in the Senate Finance Committee.

Questions? Contact Justin Beland AOPA's Director of Government Affairs at jbeland@AOPAnet.org.

NEW Education Offering – Medicare 101: Get to Know the Basics

You asked, we answered. AOPA is pleased to announce our latest educational opportunity, **Medicare 101: Get to Know the Basics**. Join AOPA experts for this one-day course March 30 in Rosemont, IL a mere five minutes from O'Hare.

Attendees will learn all the basics of Medicare billing and coding including how Medicare pays for O&P, the basic documentation needed to bill for O&P, guidelines on proper coding, and how codes are created. It will also include the popular O&P Urban Myths and Misconceptions presentation.

With this one-day program, which runs from 10am to 4pm you can fly-in and out the same day. If you need to stay, we've got you covered. You can book a room by March 9 for the special rate of \$109 at The DoubleTree by Hilton Chicago-Rosemont (location of the Seminar).

The cost, including lunch and meeting materials is \$300 for members and \$350 for nonmembers. Additionally, attendees can earn five CE credits.

Make sure you have the Medicare basics covered, register today.

Something specific you would like our experts to cover? Submit it when you register.

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

Purchase the Entire 2020 Webinar Series

February

12

1:00 PM ET

REGISTER

O&P Coding & Billing Myths: The Truth is Out There

You've heard them before...Medicare doesn't pay for '99 codes, bi-lateral patients don't require K-levels, payment rules don't apply to unassigned claims, etc. This webinar will explore these and other common O&P billing myths and provide you with the facts.

It is still a deal to purchase the entire 2020 Webinar Line-up. You'll get 12 Webinars for the price of 10. Note: we will send you the recording of January's webinar.

\$990 members/ \$1990 nonmembers

Register for the 2020 Webinar Series

Individual webinars are \$99 members/\$199 non-members.

CMS Announces Significant Changes to Requirements for Physician Orders

As part of their overall effort to reduce provider burden, the Centers for Medicare and Medicaid Services (CMS) recently announced a significant change to the requirements for physician orders for Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS). The change is effective for claims with a date of service on or after January 1, 2020 and eliminates the need for an initial/dispensing order for Medicare DMEPOS services.

Going forward, Medicare claims will only require a “standard written order” (SWO) which must be received prior to claim submission and contain essentially the same elements as the traditional “detailed written order” that has been part of the longstanding Medicare requirements for compliant DMEPOS claims. Required elements of the new SWO include the following:

- Beneficiary name or Medicare Beneficiary Identifier (MBI)
- Order date
- General description of the item
 - Can be either a general description, a HCPCS code, A HCPCS code narrative, or a brand name/model number
 - All separately billable features, additions, options, or accessories must be listed separately on the SWO
 - All separately billable supplies must be listed separately on the SWO
- Quantity to be dispensed, if applicable
- Treating/Ordering practitioner’s name or NPI
- Treating/Ordering practitioner’s signature

While initial/dispensing orders are no longer required for services to be reimbursed, medical records must continue to support the medical need for O&P services that are provided. It is important to remember that medical need must clearly be established prior to the provision of O&P care. O&P providers should confirm that adequate documentation of medical need is well documented before providing care to Medicare beneficiaries. It is also important to remember that for any claims with a date of service prior to January 1, 2020, the former rules remain in effect and, in most cases, an initial/dispensing order and a detailed written order must be received in order to maintain compliance with Medicare regulations.

AOPA believes the changes in order requirements will significantly reduce instances of unnecessary claim denials and supports the recently announced change. CMS efforts to reduce unnecessary administrative burdens on legitimate providers will allow providers to focus on providing efficient, clinically appropriate care to Medicare beneficiaries without getting caught up in unnecessary and unreasonable administrative requirements.

AOPA will continue to pursue opportunities to work collaboratively with CMS and other agencies to ensure that Medicare beneficiaries continue to have access to high quality, clinically appropriate O&P care delivered by properly qualified and credentialed O&P providers.

AOPA's 2019 Legislative Victories

Thanks in large part to your efforts, the American Orthotic and Prosthetic Association (AOPA) secured several legislative victories in 2019, positioning us to achieve even more success in the second session of the 116th Congress, which convenes on January 7. Our victories included:

- In May, Congress introduced the Wounded Warrior Workforce Enhancement Act which would authorize \$5 million per year for three years to provide limited, one-time competitive grants to qualified universities to create or expand accredited advanced education programs in prosthetics and orthotics. AOPA has been working closely with both the Veteran's Affairs Committee and Armed Services Committee to speed passage of the bill in 2020.
- Related to workforce shortages, AOPA worked with the Military Construction and Veteran's Affairs Appropriations subcommittee to add language to their FY2020 spending bill which "directs the VA to work with outside industry experts to survey and examine the latest data available on the current extent of orthotics and prosthetics care provided outside of VA facilities and provide projections on requirements over the next decade based on overall population growth among veterans with orthotics and prosthetics needs." The subcommittee has requested a report to both the House and Senate by June, and AOPA is working with VA staff to provide input to the report.
- AOPA secured a bipartisan letter, led by Reps. Elaine Luria (D-VA), Tim Walberg (R-MI), Greg Steube (R-FL), and Brad Wenstrup (R-OH), to the Chair and Ranking Member of the House Veteran's Affairs Appropriations subcommittee, urging the subcommittee "to include language to let veterans with limb loss continue to choose to receive their care from the provider who best meets their needs." In the final bill language, the subcommittee noted that the VA is "expected to ensure veterans continue to receive the prosthetics services that best meet their needs," and will continue to work with the VA to ensure veteran's choice of where they receive their care.
- AOPA worked with Congress to secure a 50 percent increase (to \$15 million) in the Department of Defense's funding bill for the Congressionally Directed Medical Research Program (CDMRP) to advance research in prosthetic and orthotic outcomes, and priorities for research to fill those gaps. AOPA will work closely with CDMRP to ensure they're receiving high quality grant proposals and funding the best available research opportunities.
- On November 22, the House introduced H.R. 5262, the Medicare Orthotics and Prosthetics Patient-Centered Care Act. While the bill enjoys broad bipartisan support, it's imperative that we add as many cosponsors as possible, to illustrate the importance of the bill to legislators. To that end and with your help, [nearly 1,100 advocates wrote to their members of Congress in support of the bill.](#) A high priority for AOPA, this bill would:
 - Restore congressional intent by revising the overly expansive regulatory interpretation of the meaning of "off-the-shelf" (OTS) orthotics to clarify that competitive bidding may only apply to orthoses that require minimal self-adjustment by patients themselves, not the patient's caregiver or a supplier.

- Distinguish the clinical, service-oriented nature in which O&P is provided from the commodity-based nature of the durable medical equipment (DME) benefit. Orthotics and prosthetics care include a patient care component that is decidedly more in-depth and personal than simply supplying DME. Most orthotic and prosthetic devices are custom fabricated or custom fit and require the expertise of an orthotist or prosthetist who receive Master of Science degrees and residence training before becoming certified practitioners.
- Reduce the likelihood of waste, fraud, and abuse in the Medicare program by prohibiting the practice of "drop shipping" (shipping an orthoses or prostheses to a beneficiary without first receiving direct patient care from a trained, certified or licensed health care practitioner) of orthotic braces that are not truly "off-the-shelf" (i.e., subject to minimal self-adjustment by the patient him- or herself).

So, what next? Continue to stay tuned for additional action you can take on the two pieces of legislation as well on other issues. Plan to attend the Policy Forum, May 5-6 in Washington DC. It is our opportunity to have our voices heard.

Thank you for your efforts in 2019, for continuing to advocate for the profession and its patients. Together we will further improve the lives of those living with limb loss and limb impairment.

If you have any questions, contact Justin Beland, AOPA Director of Government Affairs at jbeland@AOPAnet.org.

CMS Releases the 2020 Medicare DMEPOS Fee Schedule

The Centers for Medicare and Medicaid Services (CMS) has released the 2020 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 2020 Medicare fee schedule for orthotic and prosthetic services will be increased by 0.9% over 2019 rates. The 0.9% increase is a net reflection of the 1.6% increase in the Consumer Pricing Index for Urban Areas (CPI-U) from June 2018 through June 2019, combined with the annual Multi-Factor Productivity Adjustment (MFP) of -0.7%.

[View the official CMS announcement for the 2020 DMEPOS fee schedule update.](#)

[Review and download the complete 2020 Medicare DMEPOS fee schedule.](#)

Questions regarding the 2020 Medicare fee schedule may be directed to Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

2020 National Assembly Call for Papers



Contribute to high-value clinical and scientific offerings and share your expertise with over 2,000 orthotic, prosthetic, and pedorthic professionals. Submit your proposal for the American Orthotic and Prosthetic Association's 2020 National Assembly, September 9-12, 2020 in Las Vegas, NV.

We are looking for:

- [Clinical Free Papers](#) - The top scoring papers will compete for the prestigious Thranhardt Award.
- [Technician Program](#)
- [Symposia](#)
- [Business Education Program](#) - The top papers will be considered for the prestigious Sam E. Hamontree, CP (E) Business Education Award.

Abstracts will be considered for both podium and poster presentations and must be submitted electronically; e-mail or fax submissions will not be accepted. Each submission will be graded by the review committee via a blind review process, based on the following criteria.

- Relevance, level of interest in categories
- Quality of scientific content
- Quality of clinical content
- Quality of technical content

What are you waiting for? Advance your career. Gain recognition. See your name in lights. [Submit your abstract by March 20, 2020.](#)

Questions about the submission process or the National Assembly? Contact AOPA at 571/431-0876.

HCPCS Code Changes for 2020

The Centers for Medicare and Medicaid Services (CMS) has released the new Healthcare Common Procedure Coding System (HCPCS) codes for 2020, and there were a few minor changes. Below is a complete breakdown of the code changes which will be effective for claims with a date of service on or after January 1, 2020.

New Codes

HCPCS	Descriptor
L2006	Knee ankle foot device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each

Change to Code Descriptor

HCPCS	New Descriptor	Previous Descriptor
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L8032	Nipple prosthesis, prefabricated , reusable, any type, each	Nipple prosthesis, reusable, any type, each
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AOPA's Coding and Reimbursement Committee will review the list of changes and provide appropriate comments to CMS.

As a reminder registration is still open for the December 11, 2020 AOPAiversity webinar ([New Codes for 2020, Other Updates & Yearly Round-up](#)) which will focus on the changes to the HCPCS code set and any other upcoming Medicare changes which may impact your business in 2020.

Questions regarding the code changes may be directed to Joe McTernan at jmcternan@AOPAnet.org and/ or Devon Bernard at dbernard@AOPAnet.org.

HHS Office of Inspector General Releases a Report Comparing Medicare Payment for Orthoses with Payments by Other Insurers

On October 30, 2019, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a report that compared Medicare payments for orthoses to payments made by non-Medicare payers from 2012-2015. The OIG cited an increase in Medicare payments for certain spinal, knee, elbow, and wrist orthoses from \$631.8 million in 2012 to \$815.5 million in 2015 as the reason for conducting its investigation. The OIG reported that for 142 orthosis codes, Medicare paid \$337.5 million more than non-Medicare payers during the three-year review period. The OIG reported that for 19 orthotic codes, Medicare actually paid \$4.7 million more than non-Medicare payers during the same three-year period.

AOPA was aware that the OIG was considering reviewing Medicare payments for orthoses compared with non-Medicare payments, as the issue has been included in the OIG's annual workplan since 2016. Upon first mention in the 2016 workplan, AOPA notified members of the potential report and commissioned a legal memo from McGuire Woods, LLP that discussed the potential risks associated with charging Medicare more than a provider's usual and customary charges. The 2016 communication to AOPA members and McGuire Woods memo can be viewed [here](#).

In its recent report, the OIG recommended that, where applicable, the Centers for Medicare and Medicaid Services (CMS) consider using its inherent reasonableness or other authority to reduce (or to a much lesser extent, increase) the Medicare fee schedule for the 161 codes identified in the OIG report. The OIG pointed out that existing CMS regulatory authority could be used to adjust fee schedules for 95 of the 161 codes. The other 66 codes would require statutory changes to properly adjust the fees. In its response to the OIG report, CMS stated that certain off-the-shelf (OTS) spinal and knee codes have already been included in the competitive bidding program scheduled for implementation in 2021 and fees should be adequately reduced as a result of provider competition. CMS also indicated that it would consider including additional OTS orthoses in future rounds of DMEPOS competitive bidding. CMS also indicated that it has recently issued a final rule regarding calculating Medicare fee schedules for new HCPCS codes that may be useful in determining appropriate fees for new orthotic codes.

The potential impact of the OIG report will most likely take several years for CMS to implement through regulatory and legislative channels. AOPA understands the significant ramifications that

this report may have on its members, the O&P industry in general, and especially Medicare beneficiaries who may be forced to receive substandard orthotic care from unqualified, non-certified, or non-licensed practitioners as a result of arbitrary and unreasonable reimbursement reductions.

Over the next several weeks, AOPA will be performing a comprehensive analysis of the potential impact, including individual analysis of each HCPCS code discussed in the report, the current and historic O&P provider market share of each code, and the potential impact a reimbursement reduction may have on each code. Based on this analysis, AOPA will aggressively pursue all strategies that will reduce the impact of the OIG report and ensure that AOPA members can continue to provide high quality orthotic care to Medicare beneficiaries and receive equitable Medicare reimbursement. AOPA will continue to provide on this issue. The complete OIG report can be found [here](#).

Don't Sleep on the Latest AOPA Member Resource

Are you utilizing your AOPA membership? Attend the upcoming live tutorial to learn about one of the best resources available for O&P practices, the [AOPA Co-OP](#).

A Wikipedia for all things O&P, the Co-OP is a one-stop resource for information about reimbursement, coding, and policy. It is searchable database that provides up-to-date information on developments in Medicare policy, state-specific legislation, private-payer updates, and more. Members can access detailed information on everything from modifiers to product-specific L Codes and associated policies. Additionally, members can share information and insights on developments impacting the entire O&P profession.

If you haven't signed up for the Co-OP yet, this is your opportunity to learn about O&P's most comprehensive resource for coding, billing, and reimbursement. AOPA's Director of Strategic Initiatives, Ashlie White will demonstrate how to use the Co-OP and answer all your questions.

Pick the date using the drop-down menu. Register now for FREE:

- [Friday, February 14 at noon ET](#)
- [Friday, March 13 at noon ET](#)
- [Friday, April 17 at noon ET](#)

Upcoming Events

February 10-11, 2020	<i>Coding & Billing Seminar</i> Las Vegas, NV Learn more and register
February 12, 2020	<i>O&P Coding & Billing Myths: The Truth is Out There</i> AOPA Webinar Learn more and register
March 11, 2020	<i>New Technical Credits- Clinician's Corner: Orthotics</i> AOPA Webinar Learn more and register