CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Melanie Combs Dyer
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Operator: Good afternoon. My name is (Rita) and I will be your conference operator today. At this time, I would like to welcome everyone to the Data Elements for Lower Limb Prosthesis Documentation conference call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star and the number 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Ms. Melanie Combs-Dyer, you may begin your conference now.

Melanie Combs-Dyer: Thank you, operator. And thank you to everyone who has joined us here today. My name is Melanie Combs-Dyer and I'm the Deputy Director of the Provider Compliance Group at the Centers for Medicare and Medicaid Services. And I'm joined here in this office in Baltimore by several people, Dr. Michael Handrigan is our Medical Officer, the Medical Officer for the Provider Compliance Group here at CMS.

I'm also joined by (Latesha Walker) and Daniel Schwartz. And also on the phone, on the speaker's line, is Dr. Whitten. He's the Contractor Medical Director for our Durable Medical Equipment Medicare Administrative Contractor, Noridian, and we're very pleased to have everyone join us today as a resource.

The goal of this series of calls is to talk to everyone about how CMS is exploring the development of a list of suggested data elements or clinical elements that might become part of an electronic clinical template that would help physicians with the documentations that they have to author during a visit with a patient as they are evaluating their medical need for a lower limb prosthetic.

There has been a number of OIG reports and CERT error rate reports that document how oftentimes the documentation does not substantiate the need for the lower limb prosthetics that is provided for the patient. That is, the progress note that's written by the physician does not substantiate the level of lower limb prosthetics that the patient received. And so we are hoping that it may be possible to develop this list of suggested clinical elements that some

day can be part of a physician's EHR. And it could actually help them as they are evaluating the patient remember all the very important data elements that they need to collect during that patient visit.

If you have not already found it, I would encourage folks to look at our first draft of the lower limb prosthetics suggested data elements, and it can be found on our website. The best way to get there is to go to www.cms.gov/esmd. That stands for electronic submission of medical documentation. I'll say it one more time, www.cms.gov/esmd.

And then on the left-hand side, probably second from bottom, you'll see a link that says lower limb prosthesis, electronic clinical template. And when you get there, you'll get to a page that talks about really the purpose of this call, it gives you the details about the day and the time of the call. And then, just below that, it has a section called downloads. And the first link the downloads section is called lower limb prosthesis, suggested electronic clinical template.

At this point, I think I'd like to hand things over to Dr. Handrigan who can walk us through some of the sections that are in the electronic clinical templates suggested data element list, and sort of let us know what we're looking at here.

Dr. Handrigan?

Michael Handrigan: Great. Thank you. And so really our goal is to help direct the physician who is ordering the prosthetic to document the proper elements and enough of a clinical history and examination to substantiate the documentation requirements for lower limb prosthetics. And so the document that you see on the website is really a standard approach to a history and physical examination and care plan that's used across just about every specialty in medicine.

But what we have done is taken each of the sections of a care plan and added in some specific prompts to a physician or other practitioner who's ordering a prosthetic, specific prompts to help direct them to the right information to put down with respect to their ambulation needs and their ability to ambulate at baseline and with a prosthetic in the context of their overall health status.

So really, the sections are the chief complaints and history of the present illness, their past medical and surgical histories, their review of systems that would help identify other potentially important areas to document.

And then, a physical examination that looks at all of their organ systems with particular attention to those that would (impact) beneficiary's ability to ambulate. For example, the respiratory status and cardiac status. And, then of course, the musculoskeletal status to include the description of distal limb and

other limbs that would potentially affect the prosthetic device and the ability to ambulate.

And we added in several specific reminders, you'll note both in the last page as well as the first page in the introduction there is a listing of the functional levels. We don't anticipate that physicians will be routinely identifying any specific amputee functional level. But we do want to remind them that whatever functional level is ultimately chosen, whatever device is ultimately delivered to the patient, it needs to be supported by their documentation. So that's the reason we put that information into this document as a reminder.

So with that, I think what I'd like to do is to use the remainder of our call time to hear from you about what do you think should be listed in the data elements for the potential electronic document and how we could potentially change this or augment it or improve it to help serve you whether you're a prosthetic device manufacturer or prosthetist or orthotist or a physician or otherwise practitioner who's going to be ordering these devices.

So Operator, I'll turn it over to you to start taking phone calls and questions.

Operator: At this time I would like to remind everyone, in order to ask a question, please press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And your first question comes (Mark Kellick) from South Beach. Your line is now open.

Melanie Combs-Dyer: Go ahead, (Mark).

Anybody on the line at South Beach? You might be on mute, we can't hear you.

Operator: Your next question comes from Alberto Esquenazi from American Academy. Your line is now open.

Alberto Esquenazi: Thank you. Good afternoon. Thank you for the presentation. One thing that is of concern to me more than anything is the length of the documentation. I'm a physician specializing in Physical Medicine and Rehabilitation. I do prescribe prosthetic devices very frequently. And although I may document, many of these items, I think that your list is very long and may not be able to be done in the time that we currently have allotted to see a patient. And in part, the reason for this, for creating the levels of functional activity, which is inserted in your first table, was precisely to identify the patient's capacity to ambulate.

So, do you feel that this is redundant in some ways? I'll leave the question for you to answer.

Melanie Combs-Dyer: Thank you. This is Melanie and I will start and then I'll turn it over to Dr. Handrigan to help me answer the question.

I think it's important for you to keep in mind that this is going to be built into an Electronic Health Record. And so it may very well be that depending on how a physician answers one question, they may skip several other questions and go on to the next question, you know, eight questions on the list. It may be set up in a very hierarchical form. So that is to say that it may not be that the physician has to answer every single one of these data elements, it may be that they only need to address the appropriate questions. And the computer software algorithm will be set up in a way to help prompt them to which ones are appropriate for them to answer and which ones they can skip over. Dr. Handrigan, anything else to add to that?

Michael Handrigan: Yes, not much to add except that there's quite a few questions here but as Melanie described, it's meant to be the framework for an electronic data entry system. One that CMS does not plan to develop but –we want to make sure that the right data elements are available to the folks that do develop their systems. And, in fact, for any given patient, the physician or practitioner might never even see some of these questions based on the electronic data entry system.

Melanie Combs-Dyer: And this is Melanie again. Just to make sure that you guys understand the process that we will follow, we will have a series, that's the Open Door Forum probably lasting for several months and when we get to the end, then we're all comfortable with the wording of each one of the data elements and people feel comfortable with the vocabulary words that we've used.

We will then – CMS will turn over the suggested data elements to a workgroup at the Office of the National Coordinator for Health IT. Our nickname for them is ONC. Everything around here has to have an acronym but the Office of the National Coordinator will take the list of data elements and work through a framework that they have that they call their Standards and Interoperability Framework. It will be a workgroup and you guys can participate if you want but that workgroup will get way down into the weeds in terms of taking out exactly which SNOMED codes and exactly, you know, that software vendor kind of details about how the standard should be setup. And then once the standard has been created and published in the very public ONC S&I Framework, then it will be opened for software vendors to pick up and build their EHR software to meet those standards.

So that's how we see the process unfolding and that's how we'll go from what appears today to be a fairly lengthy set of documentation requirements for a

physician to a much more reasonable we think list of data elements that a physician would – and in fact, in actuality, see pop-up in their EHR at the time of the patient's visits. We'll take our next question now, operator.

Operator: Your next question comes from (Jake Wood) from ONC Associates. Your line is now open.

(Jake Wood): Can you hear me?

Melanie Combs-Dyer: Yes, go ahead.

(Jake Wood): Oh, thank you very much for taking this call. Two comments. One, I cannot tell you how my industry has been thirsting for the medical system to come up with a definition of what the doctors need to do. So I compliment you on everything that you've developed so far. We'll leave it to many others to filter out what is needed and not needed.

The primary question that I have is what is established now or what will be established in the future that is going to require the doctors to do this work? Presently, my industry is going through horrific audits where payment on our work that we've done is based on the physician's records. But as I understand it, the physicians are not required to do this and from my own personal experience and what I've heard nationally, (inaudible potions)… is that prosthetist and orthotist and I have my own practice, I'm an independent person... And we're having difficulties with physicians complying with what you want.

So do we have, for instance, or are physicians going to be required to do this, if they don't do it, they're going to be penalized. And it's an open-ended question but it's something that my profession needs drastically to find out where we're going to be after. What we're going to be able to do in the future. Thank you.

Michael Handrigan: Thank you for your question. It's not unlike many issues that we currently face. I do want to note that the use of a template be it electronic or y paper or any specific documentation style or format is entirely voluntary, and will remain voluntary as far as I know.

The use of this particular data element set is really intended to be a resource to the providers and a reminder that what has to be substantiated in their medical documentation and that they do bear responsibility for that documentation. But again, the use of this data element set or any resulting templates will be entirely voluntary.

Melanie Combs-Dyer: This is Melanie. I will only add that I think the frustration that you are expressing is a common one. We hear this from every provider type who

relies on a physician order and the physician documentation, and that's inherent in a fee-for-service program.

We do not have– statutorily, the way that the Medicare fee-for-service program is setup. We can't pay the physician, the full price of the lower limb prosthetic, and let them subcontract out with the prosthetist. That's not the way our system is setup, that's not the way the benefit, it's written, not for therapy, not for home health, not for anything else where the physician is ordering and providing the medical documentation and someone else is fulfilling order. And I think that's just inherent in the fee-for-service program.

But we do believe that this level of prompt or electronic clinical template will be helpful to – like Dr. Handrigan mentioned, we are trying it for the first time in the durable medical equipment world with power mobility devices, and this is the second one that we're trying to do an electronic clinical template. Again, to help or remind physicians exactly what needs to be documented in the patient's medical record.

So, (Jake), I hope that hopefully answered you.

(Jake Wood): (inaudible portions) …Well, it is helpful and I did not actually giving the money to the physician and having him or the prosthetist. I think that actually violates Medicare law. So that …

Melanie Combs-Dyer: Exactly. Which is …which is why we can't do it.

(Jake Wood): I know that's not intended. Right, and we're not actually asking that, I mean this is wonderful that you're finally coming up with something to tell the physicians what they're required to do. I mean right now, we are being butchered in audits because historically, there has been a pattern in the past that we have been responsible for the outcome and then physician signs off on the accepting, you know, our recommendations and – it's wonderful that you're coming up with this, I mean, I think it's great that you're coming up with this. It might be a little bit too much but that's for others to decide.

There is just a significant problem in my industry. I'm crying out from my industry because we're having great difficulty because we're not able to gather these documents because physicians – and I'm not talking all, I'm just saying some and I've taken up enough of your wonderful time on this – I've made my point.

Melanie Combs-Dyer: Well, thank you, (Jake), for your comments and for participating today. I will also say that one thing that we talked to ONC about is the possibility of doing some kind of a pilot test between the physician and the supplier or in this case, the physician prosthetist to exchange the medical documentation electronically.

Again, just to make it a little bit easier for you to see what documentation is in the medical record and, you know, appropriately proceed with a – the actual manufacture of the – and custom-fitting of the device. So we're hopeful that that kind of electronic communication between the physician and the prosthetist may also be possible someday. So thank you again for your valuable comments.

Operator, we'll take …

Dick Whitten: Ms. Combs-Dyer.

Melanie Combs-Dyer: Yes.

Dick Whitten: This is Dick Whitten, the Medical Director for Jurisdiction D. Each – just because – person who identified himself as (Jake) commented currently we have nothing to use in this capacity. I just like to point out on each of the Jurisdictions websites is a Dear Physician letter specifically identified as Documentation of Artificial Limbs. It's only about a page and a half long and it does identify in a very abbreviated form to be able to get the physician specific things we thought would be helpful for documentation from the physicians.

So until such time that the templates are available, at least data is available on the website and I didn't want to keep going with the thought that there was nothing else out there. Thank you.

Melanie Combs-Dyer: Thank you, Dr. Whitten. Operator, we'll take …

Operator: Your next question – your next question comes from (Patricia Barbara) from Zephyrhills (land). Your line is now open.

(John Russo): Hello, my name is actually (John Russo) from Zephyrhills and (Patricia) is my office manager. Got a couple of questions and maybe some observations within my industry, and I'm a prosthetist.

One, you know, we look at this draft which is great but it seems to have almost a multidisciplinary approach. You're asking for surgical and medical histories but then you're also asking for vision and psychological. So, to me, that's seems like you're going to have to see numerous physicians which in today's world is going to cost them numerous co-pays. So they're going to be inclined not to do this. That seems to me as if it's going to be one problem we're going to run into.

Melanie Combs-Dyer: Again, this is Melanie, and I would just remind you that not every question needs to be completed in every case. Dr. Handrigan?

(John Russo): OK.

Michael Handrigan: I want to also point you out that the documentation to support a lower limb prosthetic must incorporate information about the patient's overall health status.

(John Russo): Sure.

Michael Handrigan: And all of this data elements needed for any particular patient.

(John Russo): My second part of that would be, you know, you have said that the physicians may not see every element on this draft. What if any ramifications will that have for us on these RAC audits if they come back and the physician decided that it wasn't important but yet an outside contracting company decides that it was and wants to have (inaudible) for a prosthesis that we feel and according Medicare's laws, we've gone through the proper chain of command to provide this service.

Michael Handrigan: You know, I think in some ways, every patient is unique. In some there are some commonalities. The documentation to support a specific device, I think that the physician needs to understand enough of their documentation requirements to put down the information that supports the devices being delivered. So, yes, this is our attempt to help recognize the elements that broadly support lower limb prosthetics.

(John Russo): And while I do completely agree with the necessity for something like this to help both your – the physician's aspect as well as the prosthetist, you know, we're running into some of the Dear Physician letters that we're giving to some of our referral sources in May – they gave us a blind stare that they have no clue about all this, so, you know, we do welcome some type of help with this from my profession at least. Because the last time gentleman had said, these RAC audits, they seemed to be – to be unfair and I've done this for an awful long time and it definitely hurts the small business aspect of the profession.

Melanie Combs-Dyer: Just a reminder that the RAC audit as with all of the audits that are conducted by CMS and its contractors all use the national coverage policies and the local coverage policies. We sort of see the auditors as something that tend to – someone who's checking the speed, the police officer who's checking the feet of the folks going by to compare it to the posted speed limit sign. And so while I know it can be frustrating to have your cases audited, we need to make sure that we are only paying for lower limb prosthetics that meet all of our coverage requirements.

There was an Office of Inspector General, an OIG report, a little while back that showed that a very high percentage of lower limb prosthetics did not have the proper documentation to demonstrate that they met Medicare coverage requirements, and we feel obligated to the American tax payer to make sure that we lower that error rate. We need to make sure that we are not issuing improper payments that, in fact, we're only issuing payments when all of the coverage criteria are met. And so that's what has really led to the increase in the audit by a lot of our Medicare contractor that really what has led us to this point to try to find new and innovative ways to help physicians and other practitioners remember what exactly needs to be documented.

(John Russo): Lastly, and then I thank you for you time and then I will let you go. I'm looking for – to this one paragraph that says the important note to physicians and suppliers considering a financial interest. While everyone of us in every branch of medicine, whether it's therapy, physicians, prosthetist, any of us we all enjoy helping our patients and that's why we got into it. Doesn't it seem a little contradictory to say if you have a financial interest? Every physician has a financial interest that's why they do it into business?

Every prosthetist, every therapist. So that seems to me to be told that my profession as a prosthetist or an orthotist, we've had to go through schooling, we've had to go through a national certification in many stages, we have to go thru licensure for you to say that our documentation's completely insufficient, it doesn't matter. Shouldn't that be under somewhere because we are technically specialists? We are not physicians by no means but this is what we do for a living. So it's kind of difficult to be reminded that our documentation means nothing when the first thing that a Medicare auditor or any state agency or any health care companies going to do is come in and see your progress notes, your evaluation, what you provided for the patient. So isn't that kind of a Catch 22.

Michael Handrigan: Well, thanks for the comment. Let me say a couple of things then maybe Dr. Whitten may have something to say from the MAC review perspective. But the way that the benefit is written, the physician must comply with the documentation requirements. And those documentation requirements, they must be within the documentation from the physician, and that's just the way that the benefit is written. There really isn't any way around that.

And the financial considerations, I think it's important to note that in this case, the prosthetist is the supplier, and not simply medical practitioner who is rendering advice on behalf of the patient, they're actually supplying the device. So that's probably an important distinction that we should consider in this discussion. But I'll let Dr. Whitten jump in if he has anything else to add to that.

Dick Whitten: Well thanks, this is Dick Whitten. Just on behalf of the four medical directors, three others were on the plane – different planes today that's why I'm alone here but I really tried to join you.

I agree exactly with what Dr. Handrigan is saying. Yes it's true, most all cases, the K-level will be documented by the prosthetist but the requirement is that the physician's clinical record needs to support the clinical functional capabilities, the current functional capabilities. And the expected potential effect is different from the current capabilities. That's why we've often had the distinction. It's – and many prosthetists are upset because they say, well, physicians typically won't document the K-level. That's accurate and true, I didn't – but on the other hand, their record does need to show what the current status is and if it's different, what the potential functional capabilities will be. And if that's the distinction, then that has to come from the physician's record. Thank you.

(John Russo): Panel, thank you so much for your time, I appreciate it.

Operator: Your next question comes from Heikki Uustal from JFK Johnson, your line is now open.

Heikki Uustal: Hello there, this is Heikki Uustal calling. Do you here me?

Melanie Combs-Dyer: Yes we can. Go ahead.

Heikki Uustal: Excellent. I'm also a physiatrist like Dr. Esquenazi who you spoke with a little bit earlier. And I spent a lot of time looking through your template and I actually have some more specific issues I'd like to bring out as far as the way you address or the way you're achieving your documentation in the B section which is the history portion.

You I'll put it bluntly, you kind of beat around the bush as to what medical issue is maybe limiting ambulation. I find it very valuable, very helpful to clearly document what the patient's level of ambulation was prior to amputation. Literally, the three questions I ask are, when was the last time you walked on two feet? When was the last time you could walked one block outdoors? And when was the last time you could walk one flight of stairs without having to stop to catch your breath?

Now, to me those are very helpful in planning the prosthetic device but also planning out the rehabilitation after their prosthetic device. So, I would be careful that we're not getting too lost in the middle stuff which are what several of those questions in the B section relate to and try to keep it very practical and functional and maybe that even goes back to Dr. Esquenazi's question of it's too lengthy, it's too detailed, let's try to keep it simple.

And I am always telling my patient – I also see lots of amputee patients and I prescribe prosthetic devices every single day. And I would tell you, don't let the doctors get off the hook as far as documenting a K-level. If they can't learn those four simple levels, they really shouldn't be prescribing a prosthesis.

So the – my first basic comment is take that history section, try to make it more organized, brief and practical and completely have the physician document how well the patient could walk prior to amputations. If they're not going to walk any better after their amputation, if anything they're going to walk worse. So if they were limited prior to amputation, it's really going to be limited afterwards.

And then the second quick comment is in your plan section. You left it very open ended as to plan how you're going to provide to this prosthetic requirement. I would again, almost require they have a discussion with the prosthetist stating perhaps is it going to be a (inaudible) change or modification? Is it going to be a replacement of the entire prosthesis? Or ask again what category of prosthetic device the patient falls into restating that K-level to ensure that they understand what they're doing. And if therapy is going to be required because even in the Medicare documentation, it states the outcome is really based on the patient's motivation to ambulate, type of prosthesis and then rehabilitation that goes along with it. So those are just concerns to take into consideration.

As you well know, for other durable medical equipments such as wheelchairs particularly powered devices like scooters and motorized wheelchairs, we have even restricted which types the physicians can write those prescriptions, and therefore, narrowing down this broad scope that every doctor can sign for a prosthesis problem that the prosthetists are encountering now.

We have our own in-house prosthetic labs and I have six guys every single day who are telling me exactly how I need to write this stuff. And even though I've been doing this for 26 years, I'm still – everyday is making sure I'm documenting correctly to ensure that the devices don't get denied. So, there's no real question here, just some – to highlight some things to look at. And if you do have future work sessions, I'd love to be involved because I have electronic medical records that I've been using for years. It has much of the detail that you have included in their current document. And perhaps I can provide more details and insight not wasting your time now in this public forum.

Melanie Combs-Dyer: Thank you, we appreciate your suggestions.

Michael Handrigan: I think your suggestions and comments are very insightful. And I also suspect as physiatrist, you probably write multiple prescriptions and orders for

prosthetics in a regular basis. We really anticipate the value of this effort to be directed towards the general practitioner who maybe writes, you know, once in a year or once in a career to be able to go through that process of documenting properly when they don't really understand the prosthetic process very well. As opposed to a physiatrist like yourself who probably does this in their sleep two or three nights a week. I hope that's useful.

I'd also like to say that we'd be grateful if you could write some of your specific suggestions down and send them to us so that we can incorporate them into the draft that it involves.

Heikki Uustal: I would be happy to and I'm currently traveling so I can't write stuff down, but if there's a place to find either an e-mail or link, I'd be happy to send you a written suggestion.

Melanie Combs-Dyer: We will make sure that we post to the website and e-mail address where folks can send their suggestions, or comments, or ideas or how we can improve the lower limb prosthetic electronic clinical template data element list.

Heikki Uustal: Excellent, thank you for your time.

Operator: Your next question comes from (Richard Feldman) from (ABC CTL). Your line is now open.

(Richard Feldman): Hi, can everyone hear me OK, and good morning. My name is (Richard Feldman). I'm a second-generation orthotist prosthetist, and I wanted to say that the audit have been terrible, you know, for the mom and pop out there that are serving the community. You're talking about a very small profession and a very small portion of handicapped people who need them. That being said you must have heard this before.

Also, I did want to point out, there were some, you know, something about, you know, classifying our professional into the or that we had DME issues and there was also a point you guys where, you know, we – it must be some point, some area of our population, we – those are words that really get up our dander. We are – and have been progressing since 1954 to be separated from (DME/OPS) categories. We have now, you know, permanent school sites since '70s to have a four-year degree and have two years of service discipline as interns, you know, to take on these responsibilities were actually, you know, we promote our patients care and we're proactive for them.

So, you know, I agree, profit is necessary for everybody to continue their livelihood or their research, or their humanitarian, you know, pursuits. But first and foremost I think for the most of us that have been professionalized through this system now, we don't see ourselves as DME providers and so that

would be something for the CMS people to be aware of. It is not something that we see ourselves as.

So, that might be a problem right there. We would like to be separated from the – from the DME world. The other part is that I am glad to see that more physicians are on the line and that are, from Dr. Whitten, he said our medicals are, you know, are important in review of functional levels.

We are upset that, however, that our notes are not relative to be important enough to be valued as a part of the medical documentation. It's what I have seen through the, you know, e-mails that I've read.

The other issue I have is in maybe you can let me know if this is a rumor or not. The CMS review audits on the auditors, are they actually getting a percentage of what's been refunded to CMS or HHS? And if that is so, that makes them biased. The other point is that there is no prosthetist or orthotist I know that will go in or has, repossessed a limb or a brace and there wouldn't be any value in that because our services are really based on our professional labors that the value of what you get for a used component would actually be taken up with the manufacturers, and I'm sure they don't want repossess and they would not be able to sell anything on eBay.

So, can you address those areas I've talked about, please?

Melanie Combs-Dyer: Sure, this is Melanie. And the first point that you make is that prosthetists and orthotists are separate from DME suppliers and we agreed and we apologized if anything and what we've said. It made it sound like we were calling you – the DME suppliers, we are not, we recognize that prosthetist and orthotist are separate. But we do recognize that orthotist and prosthetist function like anybody else in the fee-for-service world, in your level of frustration that the items and services that you are providing must be ordered by a physician and documented by the physician, it doesn't matter if it's x-rays, or MRIs, or therapy, or home health, or hospice, all of those services are ones that need to be ordered and documented by a physician and I noticed that's frustrating for many of you.

So, yes we recognize that you are different from DME suppliers but much like DME suppliers and lots of other types of what I call third party providers in Medicare, you – your payments in part are reliant on the physician's order and the physician's documentation.

Second, you talked about how you don't feel like the Medicare program values your notes and I will give you my comments on that and then I think I'll ask Dr. Handrigan and Dr. Whitten to speak on that as well. I do believe that the prosthetist notes are very valuable but that does not obviate the need for the

physician documenting other patient's medical need and medical level of functional ability.

And before I go on to your third question, let me turn it over to Dr. Handrigan and Dr. Whitten to speak a little bit more about the importance of the prosthetist note.

Michael Handrigan: Yes, I think we recognized that prosthetist and orthotist, they have had a unique valuable skill set and that the documents that they provide are important in the overall documentation, but we have the medical reviewers look to documentation to support the integral necessity for any device or service. Specifically with (inaudible) prosthetics, the order needs to be substantiated within the context of the beneficiary's overall health status and that's something that only the physician who was ordering the device, can put into the medical record.

So, while we recognized the importance the prosthetists attribution it's the physician who must make the overall evaluation and determination within the medical record in the context of the patient's beneficiary's overall health status. I hope that helps clarify your question a little bit.

Male: I never had any doubt that the physician was the main, you know, man in-charge or women in-charge, that was never a doubt in my head, it was just that the – what I had read and interpreted as our notes not being counted or they're not being considered part of a medical record was disturbing.

Melanie Combs-Dyer: This is Melanie again. And on your third point about asking, do the auditors get paid a percentage of what they find? The answer is yes and where staff is really required to do it that way.

For many years at Medicare program, we only have one type of auditor, the Medicare Administrative Contractor. The Medicare Administrative Contractor performs a number of tasks, they received the claims from you and others, they write the policies, the local policies, Dr. Whitten is very involved in that, and they perform audits or what we would call medical reviews. But they are quite expensive and year after year we would go to Congress and ask for more money to do more medical review to get down our improper payment rate. And Congress a few years ago passed the law that required CMS to higher recovery audit contractor and pay them a contingency fee for every improper payment that they find. They do have to pay back that contingency fee if they lose on appeal. But we believe that that is a very valuable tool to help us identify improper payment and help us to lower our rate of improper payments.

Operator, can you …

Unidentifiable male: Well, that's a little disturbing. And that they have their own financial incentives and their own bank to testify their findings which are bias for their selves.

Melanie Combs-Dyer: Operator, could you please take one last call, and then we'll give a couple of closing thoughts.

Operator: Your next question comes from (Daniel Bastian) from Progressive OMP, your line is now open.

(William Lyford): Hi, this is actually (William Lyford). I'm certified prosthetist here in Long Island New York.

My first question is that, will a transcription of this call session and question and answer session be available online afterwards?

My second question is that in the – that this list looks more like a list of reasons to deny a prosthesis to a beneficiary rather than a list of supporting evidence to support the provision of a prosthesis. It looks to me like a checklist to find a reason to deny.

And my third point is that, are we suppose to deny services to Medicare beneficiaries when the physicians failed to comply with the documentation requirements, because as you can see their level of cooperation of complying with the requirements specified in the Physician Letter has been abysmal.

And so, I'm wondering what are – are we suppose to start denying service to Medicare beneficiaries?

Melanie Combs-Dyer: (William), thank you for your questions and we'll try to answer them very quickly.

The first question is to (inaudible) address if transcript will be available and I don't know the answer to that, but I'm (inaudible) not sure and we will post the answer to that question on our website. If a transcript is available, it would on the same website where you found the call-in information about this call.

(William Lyford): OK.

Melanie Combs-Dyer: Your second question was that the data element list looks like a list of reasons to deny. We don't see it that way.

Dr. Handrigan, anything you want to add to that point?

Dr. Handrigan: Yes, I think, and Melanie, you're definitely right. This is our intent to help physicians and other practitioners who were ordering these devices to

understand. And so what they may need to put down to substantiate your patient.

Melanie Combs-Dyer: And your third question – I'm sorry (inaudible) a little bit of feedback.

(William Lyford): In response to that, you know, when I look at some of these questions like the – is the beneficiary's vision sufficient to ambulate safely. We have a number of patients, for example, that has vision impairments that ambulate better than I do? And for example, I happen to work with the lower limb amputee who is – who has congestive heart failure and cardio myopathy.

So I'm concerned that somebody that is an amputee that's well served by K3 level of prosthesis, their lists of diagnosis will then be use to deny provision of the prosthesis to them.

Melanie Combs-Dyer: (William), we do not intend this list to be a list of (reasons) to deny coverage to the beneficiary. But we do appreciate your comments.

We've got about 30 seconds left before the call ends. So I just want to let everyone on the line know that we do intend to have a series of future calls. Dan Schwartz, do you have the date and the time of the next call?

Daniel Schwartz: Yes. The next call is currently scheduled for June 13th at 4:00 p.m. Eastern Time. I actually also have a call-in information as well.

Melanie Combs-Dyer: That's OK. I think we can put that …

Daniel Schwartz: We'll put that on the web (inaudible) …

Melanie Combs-Dyer: You guys just put June 13th, that's 4:00 p.m. Eastern Time on your calendars. If there are any changes to that date or time, we will post back to our website. And we will post to the call-in and for the dial-in information as well.

We'd like to thank everyone today who participated. We think this is a valuable exchange. We really appreciate all of your inputs. And again we will be posting to our website and e-mail address where you can send us any suggestions, if there's things that you think could be worded better in our data element list, we would love to hear from you.

Operator, let me turn it over to you to bring the call to an end.

Operator: This concludes today's conference. You may now disconnect.

END