March 8, 2013

George G. Mills, Jr., Director, Provider Compliance Group
Centers for Medicare and Medicaid Services
Office of Financial Management
Mail Stop C3-09-27; Room C3-09-17
7500 Security Boulevard
Baltimore, MD 21244

Subject: Prosthetist Notes in Medical Record

Dear Mr. Mills:

I am writing to inform you of, and to request your action to ameliorate, a recent inappropriate action undertaken by one of the Medicare contractors. This relates to whether the prosthetist's notes of visits with a Medicare amputee beneficiary patient become a legitimate part of the patient's medical record when those notes are received by, reviewed by, and entered by the patient's physician into their file, whether hard copy or electronic, which the physician maintains on the past, current and future health care of that patient.

Specifically, I am referring to the attached announcement issued by Jurisdiction B, which is attached and which stated:

Note: *Suppliers are reminded per the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Program Integrity Manual, Chapter 5, Section 5.7-5.9, supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.*

In May, I was among a small contingent of individuals representing the Orthotic and Prosthetic Alliance who met with you, Ms. Melanie Coombs-Dyer, Dr. James Rollins and Dr. Susan Miller. At that meeting we had raised the question of the medical record because there had been an oral statement by a specific DME MAC Medical Director at an earlier public meeting that the prosthetist's notes would not be considered a legitimate part of the patient's medical record. We had also reported that a contrary position had been announced subsequently by one of the CMS internal employee Medical Directors who had participated in a meeting the O&P Alliance had arranged with Mr. Laurence Wilson.

Dr. Miller had stated during our May meeting that in the circumstances outlined above the prosthetist's notes do indeed become part of the patient's medical record. Dr. Miller

indicated that there must have been some confusion or misunderstanding on the part of the contracted DME MAC Medical Director who had made a statement to the contrary. Dr. Miller promised that she would assure that all DME MAC contractor personnel were timely apprised of that determination by CMS relating to the prosthetist's notes. We were reassured by Dr. Miller's commitment, and looked forward to that issue being clarified at last.

Given Dr. Miller's statements, we were very surprised when we saw the Jurisdiction B announcement within the past six weeks advising that the prosthetist's notes are not part of the patient's medical record. We are not sure what may have gone awry—whether the notification promised by Dr. Miller was either not received or not understood by the Medicare DME MAC contractors, but it is clear that this 'confusion' continues. The purported basis for the 'exclusion' of the prosthetist's notes is that since the prosthetist is a provider and the amount of Medicare payment he/she receives may be affected by the observations made and notations he/she records from one or more examinations and clinical visits with the patient, that the notes' legitimacy is somehow compromised. The fundamental flaw in that logic is that the same is true of most health care encounters and professionals with whom Medicare beneficiaries/patients have contact. The prosthetist's notes are just as legitimate a part of the medical record as the surgeon's report on a pre-surgical consultation, the subspecialist's report, and the radiologist's notes on an x-ray report (which if inconclusive might require more advanced imaging studies).

AOPA believes that this errant contractor activity/interpretation needs to be quickly and decisively corrected. We therefore request that you immediately reverse this recent Jurisdiction B policy statement and instruct the Jurisdiction B contractor to cease and desist from such statements and practices that are contrary to CMS policy. We also request that you notify the remaining Jurisdictions to refrain from any similar policies that could operate to the detriment of disabled individuals, in this case Medicare amputees. Amounts already withheld from providers as a result of any cases in which a claims review has been based on any patient record/physician file which has not included the prosthetist's notes should be returned conclusively and in full with interest to the prosthetic providers.

Fairness in the Medicare system demands strong and effective oversight and of Medicare contractors. This represents an instance in which we believe that oversight and management has been lacking, and needs to be remedied immediately to avoid further severe and potentially irreparable damage to Medicare disabled beneficiaries.

We would be pleased to discuss directly, on an expedited basis, any questions relating to this requested action. We believe immediate Medicare intervention is required.

Very truly yours,

Thomas F. Fise, J.D.

Executive Director

cc: Marilyn Tavenner, CMS Administrator
James Rollins, M.D.
Susan Miller, M.D.
Melanie Combs-Dyer
The Honorable L.F. Payne, MaguireWoods
Thomas A. Scully, Esquire, Alston & Bird
Thomas Mills, Esquire, Winston & Strawn

National Government Services

Jurisdiction B Daily News

Documentation for K Levels for Prosthetics

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) has received several inquiries in regards to what documentation must appear in the medical record to support the K level for prosthetics.

Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

1. The beneficiary's past history (including prior prosthetic use if applicable); and
2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
3. The beneficiary's desire to ambulate.

This information must be documented by the **treating physician and the prosthetist**.

The medical record should reflect that a comprehensive medical assessment has occurred. The medical record should include, but is not limited to, past history, current functional capabilities and the beneficiary's expected functional potential, including an explanation for the difference, if that is the case. The medical record should establish the severity of the beneficiary's condition and the immediate and long term need for the prosthetic and the therapeutic benefits the beneficiary is expected to realize from its use. An entry in the medical record of therapeutic effectiveness or benefit based on speculation or theory alone cannot be accepted. When restoration of function is cited as a reason for use of the prosthetic, the exact nature of the deformity or medical problem should be clear from the medical evidence submitted. Also, the manner in

which the prosthetic will restore or improve the bodily function should be explained by the treating physician. The K-level selected must be consistent with the overall health status of the beneficiary.

Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of prosthetic.

Note: Suppliers are reminded per the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, *Program Integrity Manual*, Chapter 5, Section 5.7-5.9, supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.